# Globalization and Nursing Practice: A Phenomenological Study of the Lived Experiences of Nigerian Registered Nurses Working in the United States' Healthcare Industry in Northern California

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Globalization and Nursing Practice: A Phenomenological Study of the Lived Experiences of Nigerian Registered Nurses Working in the United States' Healthcare Industry in Northern California

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## Dedication

My soul magnifies the Lord

And my spirit rejoices in God my Savior; … (Luke's Gospel 1:46-55)

It is with great gratitude that I give thanks to God granting me the blessing of mental and physical capabilities, as well as the resources to support this academic journey. I dedicate this dissertation to my family- wonderful and loving husband, Dr. Inno Ekeh, who has been the wings beneath my wings in my pursuits of life. To my sons Innocent and Ike who have provided me with moral and technical support throughout this academic journey, thank you. I also dedicate this dissertation to my mother (Evelyn) and all my siblings and their families, the memories of my late father (Samuel), and my grand uncle-in-law (Boniface) who all always wished the best for me as I grew up and embarked on the journey of knowledge acquisition to fulfill my dream of being a scholar. This work is also dedicated to all the nurses around the world who choose to nurture and care for humanity in the continuum of life regardless of culture or creed.

**Acknowledgments**

As the popular saying goes, 'it takes a village to raise a child.' In that regard, I acknowledge and thank all who have influenced and directed me in the course of my academic pursuit. I would like to express my gratitude and thanks to the following people.

Thank You

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To the participants of this study who enthusiastically shared their experiences to make this research possible.

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## Abstract

Globalization and Nursing Practice: A Phenomenological Study of the Lived Experiences of Nigerian Registered Nurses Working in the United States' Healthcare Industry in Northern California

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Chairperson: Kathy D. Geller

Globalization has made it possible for leaders in the United States' (U.S.) healthcare industry to access global labor market to fill vacant nursing positions in their organizations. A significant number of registered nurses from other countries have been hired to work in the U.S. healthcare industry. Inherent in hiring these nurses is difference in culture and professional practices.

Registered nurses from Nigeria have been identified as a growing population within the nursing workforce in the U.S. healthcare system. For nurses who are born in other countries and licensed to practice nursing in the U.S. healthcare industry, there is need for them to become acculturated to the new environment when they move from their country of origin (Ea, 2008; Kawi & Xu, 2009; Kishi, Inoue, Crookes, & Shorten, 2014; Xu, Gutierrez, & Kim, 2008). While there is significant research on nurses from other cultures, there is limited research on the lived experiences of registered nurses from Nigeria who live and work in the U.S. healthcare industry. The purpose of this phenomenological study was to explore the lived experiences of Nigerian registered nurses working in the healthcare environment in Northern California.

The lived experiences of Nigerian registered nurses were gleaned using three research questions: (a) How do the Nigerian registered nurses describe their challenges working in the U.S. healthcare environment in Northern California? (b) How do the Nigerian registered nurses describe the affect of the challenges on their personal and professional lives? (c) What are the perceived attributes for success identified by the Nigerian registered nurses working in the healthcare environment in Northern California?

Purposeful sampling and snowball methods were used to identify 16 participants. Data were collected using 18 semi-structured interview questions, field-notes, a researcher journal, and a review of relevant artifacts. Interviews were tape-recorded, transcribed verbatim, categorized, and coded for themes. Four themes—influences to become an registered nurse, developing professionally, transitions experienced, and responding to challenges—and four results—universality of fundamental core nursing clinical practice skills, grassroots effort in seeking access into the nursing profession, microaggressions, and limited support and need for resiliency—emerged from data analysis providing insights into and better understanding of the experiences of Nigerian registered nurses working in the healthcare environment in Northern California, leading to evidence-based conclusions and recommendations.

**Keywords**: globalization, culture, communication, clinical competency, microaggressions, Nigerian registered nurse, Critical race theory (CRT), United States healthcare industry

# Chapter 1: Introduction to the Research

According to Gambino, Trevelyan, and Fitzwater (2014), the Nigerian population has become a recognizable subgroup within the United States (U.S.). Three million registered nurses were licensed in 2008 in the United States and 2.6 million of the nurses were subsequently employed. International nurses represented 8.4% of the 3 million licensed nurses, and Nigerian nurses represented 2% of the 8.4% international nurses licensed in the U.S. (Shaffer, 2014, p. 10). The Nigerian population has become a recognizable subgroup within the U.S. nursing workforce; Nigerian registered nurses are likely to continue joining the nursing workforce in the U.S., as agencies including the Health Resources and Services Administration and the National Center for Workforce Analysis predicted that nursing job vacancies will reach 800,000 by the year 2020 and the American Organization of Nurse Executives has acknowledged the need for foreign-born nurses to sustain quality patient care (Sherman & Eggenberger, 2008).

Kline (2003), as well as Brush, Sochalski, and Berger (2004) have noted that Nigeria is one of the top six countries in the world with the highest number of registered nurses working in the U.S. healthcare industry. Records also show that Nigeria is among the top 10 countries in the world whose nurses have taken the qualifying nursing examination overseen by the Commission on Graduates of Foreign Nursing Schools (Brush, 2008). Brush (2008) identified that between 2000 and 2006, Nigeria was ranked third after the Philippines and India with 2,425 nurses passing the examination during that period. Once licensed by the Board of Registered Nursing (BRN), these nurses become eligible to work in U.S. healthcare industry.

Being registered nurses in the U.S. seemingly suggests that Nigerian nurses are adjusted to the diverse professional cultures in U.S. healthcare industry. As Nigerian registered nurses

reside and work in the U.S. healthcare system, several forces are likely to affect their lives and wellbeing. They likely face challenges working in a country with a culture alien to that of their own homeland. Jones and Sherwood (2014) identified forces that might limit the success of nurses from another country including, "economic, cultural, social, [and] educational" assimilation (p. 59). As Bola, Driggers, Dunlap, and Ebersole (2003) noted, "Somebody has to manage the foreign nurses' assimilation into their new organizations" (p. 39).

## Statement of the Problem to Be Researched

Little is known about how the U.S. healthcare environment presents challenges for registered nurses (RNs) from Nigeria working in the U.S. healthcare industry.

## Purpose and Significance of the Problem

### Purpose Statement

The purpose of this phenomenological study was to explore the lived experiences of Nigerian registered nurses working in the U.S. healthcare environment in Northern California seeking to understand the cultural, social, and educational challenges they face.

### Significance of the Problem

Research has shown that for nurses from other countries who are licensed to practice nursing in the U.S. healthcare industry, there is a need for them to become acculturated to the new living and working environments when they move from their country of origin (Ea, 2008; Kawi & Xu, 2009; Kishi, Inoue, Crookes, & Shorten 2014; Xu, Gutierrez, & Kim, 2008). While there is significant research on nurses from a range of other cultures, there is limited research on the lived experiences of registered nurses from Nigeria who live and work in the U.S. healthcare industry.

Nursing practice in familiar environments assumes basic cultural understanding in providing care (Jones & Sherwood, 2014). Challenges in the areas of language and communication, clinical skills, and the general understanding of the healthcare system in the U.S. have been noted among the transitional issues for registered nurses from other countries (Edwards & Davis, 2006). Kawi and Xu's (2009) study concluded that a lack of training and support during transition into the U.S. healthcare environment poses significant threats to safe patient care. Furthermore, Kawi and Xu observed, "adjustment involves adaptation to personal, professional, social, cultural and organizational experiences in new environments" (p. 175).

Registered nurses in the U.S., including those from other countries are required to adhere to the regulatory requirements of the U.S. healthcare industry (Xu, Shen, Bolstad, Covelli, & Torpey, 2010). Both academic and background checks are conducted on foreign-trained nurses before they are admitted to take the Council Licensure Examination for Registered Nurses (NCLEX-RN®). Language assessments are also conducted, and nurses who meet the requirements are awarded certificates to show they are proficient and able to effectively comprehend the use of the English language.

While nursing licenses are certified by the BRN in every U.S. state, there seem to be no cultural assessments performed to ascertain that the registered nurses from other countries working in the U.S. healthcare industry understand the cultural nuances inherent in their new work environment. Little is known about how these nurses understand the differences in communication within the hiring healthcare organizations, or in the various cultural layers in U.S. society. Understanding the lived experiences of Nigerian registered nurses working in the Northern California healthcare system may enable regional healthcare organizations to identify resources to better support their acculturation.

## Research Questions Focused on Solution Finding

The following questions guided this research study.

1. How do the Nigerian registered nurses describe their challenges working in the U.S. healthcare environment in Northern California?
2. How do the Nigerian registered nurses describe the effect of challenges on their personal and professional lives?
3. What are the perceived attributes for success identified by the Nigerian registered nurses working in the U.S. healthcare environment in Northern California?

## Conceptual Framework

### Researcher Stances and Experiential Base

I approached this study through the lens of social constructivism. Social constructivism is based on the understanding that what is real to people is determined by the social, cultural, and historical experiences of the people involved (Bloomberg & Volpe, 2012). In addition, the social constructivist perspective assures that in gathering data, I focus my attention more to "the views, values, beliefs, feelings, assumptions, and ideologies of individuals than in gathering facts and describing acts" (Creswell, 2012, p. 429).

Using a qualitative phenomenological research design, I assumed the responsibility for exploring and interpreting the social, cultural, and historical experiences of Nigerian registered nurses through their representations of their lived experiences within the U.S. healthcare environment. As a researcher, I am aware that my own worldview may influence the data analysis process and that I will need to bracket my own experiences to prevent personal bias from influencing the outcomes of the study. I am a Nigerian registered nurse with over 20 years of experience working in an acute care hospital setting in a world-renowned medical center in

the western United States. While I was born in Nigeria, I obtained my professional nursing education (both BSN and MSN degrees) in the U.S. While conducting this research, I was an Adjunct Faculty teaching clinical nursing skills in a nursing program in Northern California.

Phenomenological study as a form of qualitative research design seeks to understand people's lived experiences based on the individuals' worldview (Merriam, 2009). Phenomenological study design "unveils the description, meaning and essence of the experience" (Salmon, 2012, p. 4). It incorporates in-depth interviews to explore and find meaning in participants' lived experiences (Merriam, 2009). As the researcher for this study, I incorporated the process of epoché to bracket my biases and assumptions, creating a better position to focus on finding the meaning of the lived experiences as described by the participants (Moustakas, 1994). Reflecting on this experience, I bracketed any previous beliefs and assumptions about my lived experiences regarding culture, communication, and clinical competencies.

**Conceptual Framework**

This phenomenological research was developed on a foundation of existing research in: (a) culture, (b) communication difference, and (c) clinical practices and competencies (3 Cs) within nursing care. These three streams of theory, research, and practice represent the medium through which to understand the lived experiences of Nigerian registered nurses working in the U.S. healthcare environment in Northern California. Figure 1 offers a graphical representation of the conceptual framework and identifies the components that guided this study.

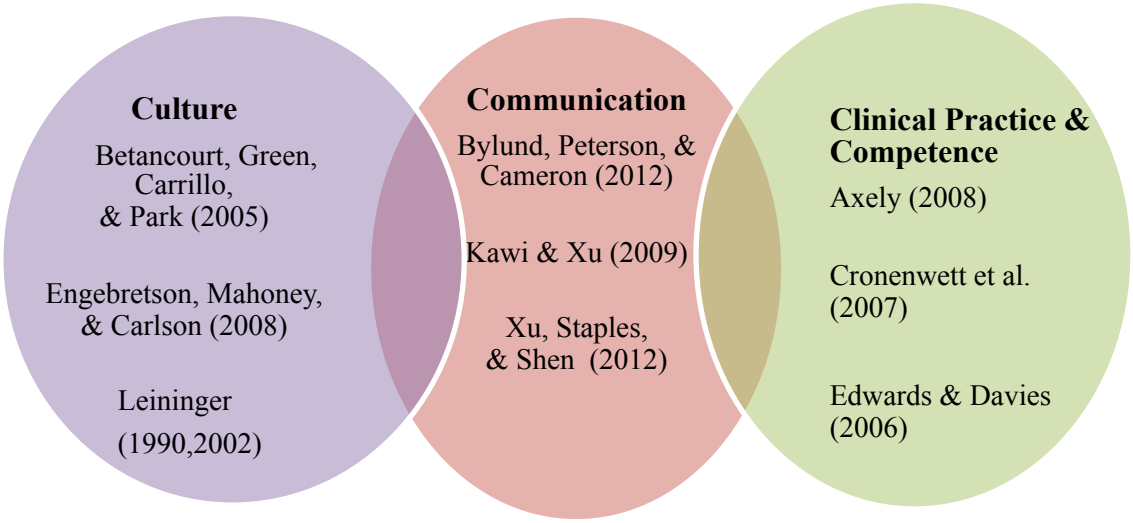


*Figure 1*. Conceptual framework: Nigerian nurses working in healthcare in Northern California.

**Culture.** As it relates to this study "culture is a blueprint for thoughts and behavior, and it is a dominant force in determining health and illness caring patterns and behaviors" (Yi & Jezewski, 2000, p. 722). Betancourt, Green, Carillo, and Park's (2005) study concluded that cultural competence is important in assuring safe care to patients from diverse backgrounds. Spector (2004) described the use of the components of Cultural Care Theory (CCT) as healthcare that considers the holistic context of the care receiver as an individual in a specified community for interpretation of health and illness. Required in this situation is that the caregiver be culturally competent, appropriate, and sensitive (Spector, 2004). This requirement becomes the responsibility of healthcare agencies to meet national standards mandated by government agencies for culturally and linguistically appropriate services (CLAS). The healthcare industry

relies on all registered nurses, including those from Nigeria, to meet the CLAS standards. Figure 2 offers an illustration of the layers of cultural practices that likely impact nursing practice.

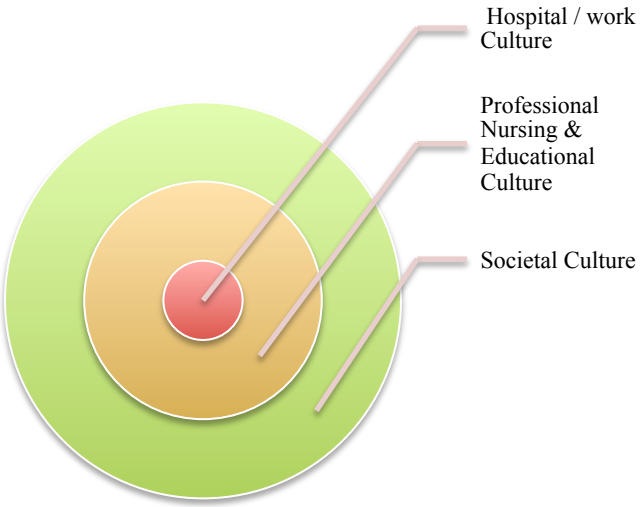


*Figure 2.* Layers of cultural influences on nursing practice.

The hospital work culture, the professional nursing culture, and societal culture all exert influences on nursing practice and present a challenge for registered nurses from another culture (Dreher & MacNaughton, 2002). As represented in Figure 2, societal culture has the largest cultural influence. Professional nursing and educational cultures represent the identified scope of training and practice guiding the nursing practice. Finally, the hospital and work culture provides the rules and regulations governing nursing practice in the hospital environment. The influences of the layers of culture on nursing practice are discussed further in the literature review (Chapter 2).

**Communication differences.** Professional nursing practice relies heavily on many forms of communication. It has been noted that communication in the U.S. healthcare environment involves the understanding of the English language (both spoken and written) and

nuances of the American society. Towards that, Spector (2004) noted that communication is comprised of language, behaviors, and silence. Ineffective forms of communication can hinder appropriate and safe care. Verbal, as well as non-verbal, forms of communication are used in delivering healthcare (Bylund, Peterson, & Cameron, 2012; Maier-Lorentz, 2008). To be successful as a registered nurse in the U.S. healthcare environment, it is imperative for one to have an understanding of all aspects of communication.

In the U.S. healthcare environment, it is critically important to communicate effectively with other healthcare professionals, patients, and their families. Thus, understanding how to communicate with people from other cultures, including different regions of the U.S., and understanding the various forms of communication developed for people with special needs (e.g., blind, mute and deaf) are necessary to achieve safe patient care and successful clinical practice (Spector, 2004). Scholars have identified communication as part of the difficulties registered nurses from other countries encounter. They have noted that success emerges only after elimination of the obstacle posed by communication and language barriers (Xu, 2010; Xu et al., 2008). The impact of communication in nursing practice is highlighted in subsequent chapters.

**Clinical competence.** Although all registered nurses may be trained in clinical nursing skills, some nurses from other countries appear to encounter difficulties in understanding the nursing clinical competencies used in the U.S. healthcare industry (Xu et al., 2008). The knowledge of medications used in patient care and their particulars, (name, indication for use, dose, and frequency of medication use, side effects, contraindications, and patient education) was described by Sherman and Eggenberger (2008) as being different in different countries. Not understanding these differences may create a possible source of harm to the patient and legal

ramifications for the registered nurses and healthcare institutions (Chandra & Willis, 2005). Parrone, Sedrl, Donaubauer, Phillips, and Miller (2008) noted that though the curriculum of study in the Philippines has been adjusted to reflect the U.S. system, the unit of conversion for medications in the Philippines is different than the unit of conversion in the U.S. The differences in clinical training and medical terminology based on where the nursing training is received have implications for the quality of hospital safety and care.

## Definition of Terms

### Clinical Competency

> In this study, "Clinical competence is described as the theoretical and clinical knowledge used in the practice of nursing, incorporating psychomotor skills and problem-solving ability with the goal of safely providing care for patients" (Wu, Enskar, Lee, & Wang, 2015, p. 348)

### Critical Race Theory (CRT)

> "A tool that is aimed at helping people understand social structures that dominate and oppress" (Rocco, Bernier, & Bowman, 2014, p. 458)

### Culture

> In the broadest sense, refers to a way of life belonging to a designated group of people . . . culture includes all the accumulated ways a group of people have lived and perpetuated their culture through a long period of time. It is reflected in the people's language, dress, food, tradition, and human-made material items as well as the many social institutions which embody and sustain these cultural lifeways. (Leininger, 1990, p. 54)

### Culturally Appropriate

> "Implies that the provider applies the underlying background knowledge that must be possessed to provide a given patient with the best possible health care" (Spector, 2004, p. 8)

**Culturally Competent**

In this context, means "one possessing the attitudes, knowledge, and skill necessary for providing quality care to a diverse population" (Loftin, Hartin, Branson, & Reyes, 2013, p. 2).

**Culturally Sensitive**

The ability to effectively understand, appreciate, and respond to others' cultural preferences (Maier-Lorentz, 2008).

**Dominant Culture**

Dominant culture can be described as the culture among cultures that uses economic, political, and communication power to enforce the use of its beliefs, values, language, and behavior patterns as the mainstream cultural components (Marshall, 1998).

**Globalization**

"The process of achieving higher productivity and efficiency by identifying and focusing on an organization's efforts and resources in major world markets" (Van Tiem, Moseley, & Dessinger, 2012, p. 389).

**Microaggressions**

> Brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group. They are not limited to human encounters alone but may also be environmental in nature. (Sue Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007, p. 273).

**Microassault**

Microassault refers to the "explicit racial derogation characterized primarily by a verbal or non-verbal attack meant to hurt the intended victim through name calling, avoidant behavior, or purposeful discriminatory actions" (p. 274).

**Microinsult**

"Characterized by communications that convey rudeness and insensitivity and demean a person's racial heritage or identity. . . . represents subtle snubs, frequently unknown to the perpetrator, but clearly convey a hidden insulting message to the recipient of color" (p. 274).

**Microinvalidation**

Microinvalidation is the third type of microaggressions "characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color" (p. 274).

**Registered Nurse**

Registered nurse describes an individual who has completed a specified professional nursing training program and passed the NCLEX-RN® administered by a specific state BRN **(**Potter & Perry, 2005).

**U.S. Healthcare Environment**

A "multiservice [medical] institution providing interdisciplinary medical care" (Jonas, Goldsteen, & Goldsteen, 2007, p. 64).

## Assumptions and Limitations

**Assumptions**

Bloomberg and Volpe (2012) explained that assumptions "reflect what you hold to be true as you go into the study and from which you believe you will be able to draw some conclusions" (p. 66). This qualitative phenomenological study was based on several assumptions the researcher held about the interrelatedness of culture, communication, and clinical

competency and their implications on the Nigerian registered nurses working in U.S. healthcare industry. The specific assumptions in this study included:

1. This study will provide information to better support assimilation, training, and education for future registered nurses from Nigeria.
2. Nigerian registered nurses have limited resources to guide their transition and practice of nursing in the U.S. healthcare environment.
3. Registered nurses from Nigeria who lived in the U.S. prior to starting a nursing career encounter less practice challenges in the areas of culture, communication, and clinical competence than those who were recruited to work from Nigeria.
4. Registered nurses from Nigeria likely have to set aside their own cultural understanding to understand the dominant cultural approaches to patient care in the new healthcare environment.
5. This study may evoke some emotions in registered nurses from Nigeria about their lived experiences.

**Limitations**

This study is limited to the lived experiences of a small number of Nigerian registered nurses working in the U.S. healthcare environment in Northern California. This region has a highly diverse population and the results from this research may not represent the experiences of Nigerian registered nurses working in other parts of the U.S. Furthermore, the study sample was based on purposeful and snowball sampling to secure the 16 participants. The perceptions and opinions of the participants reflect their own experiences, and their applicability to Nigerian nurses working in the United States cannot be assumed.

## Summary

This chapter explored the globalization of nursing practice and the challenges encountered by Nigerian registered nurses working in the U.S. healthcare environment in Northern California. The conceptual framework of this phenomenological study was anchored on culture, communication differences, and clinical nursing competencies (Betancourt et al., 2005; Leininger, 2002; Spector, 2004). As the nursing shortage appears to linger (some people will say with no end in sight), healthcare organizations in the U.S. likely will continue to look to the global market to fill their vacant nursing positions. Thus, there is the need to understand the lived experiences of Nigerian registered nurses working in the healthcare environment and how they succeed despite the difference in culture, communication, and clinical nursing competencies.

# Chapter 2: Literature Review

## Introduction to Chapter 2

Studies on registered nurses who are not originally from the country where they are employed have identified challenges in nursing practice in the areas of culture, communication, and clinical practice (Alexis, Vydelingum, & Robbins, 2007; Bola et al., 2003; Jose, 2011; Kishi et al., 2014; Lin, 2014; Magnusdottir, 2005; Parrone et al., 2008; Tan & Alpert, 2013; Xu et al., 2008; Yi & Jezewski, 2000). The paucity in research on the lived experiences of Nigerian registered nurses working in the U.S. healthcare industry makes this study compelling. Prior research depicting the experiences of registered nurses from other countries provides a necessary background for the study of Nigerian registered nurses working in the U.S. healthcare environment.

## Literature Review

This literature review explores scholarly publications on culture, communication, and clinical competence and their applicability in nursing practice. It queries studies on the lived experiences of nurses from countries similar to Nigeria to substantiate if culture, communication, and clinical practice principles affect nursing practice. This literature review extensively explores culture, communication, and clinical competency theories that are fundamental to nursing practice.

Globalization and a shortage of registered nurses in the U.S. has led to the hiring of registered nurses from other countries to provide quality health care for patients. As noted in Chapter 1, culture, communication differences, and clinical competence—the "3 Cs" for this study—are the three streams of theory, research, and practice forming the conceptual framework

that inform the current study. This literature review explores the component parts of these three streams. The literature reviewed is used as a benchmark to understand the practice challenges Nigerian registered nurses working in Northern California encounter working in the healthcare environment.

**Culture**

Culture is a broad concept that describes the "way of life belonging to a designated group of people" (Leininger, 1990, p. 54). Human history seems to indicate that survival has been based on cultural beliefs and actions. Leininger (1990) noted, "the long history of humans reveals that they have developed and survived through diverse cultural experiences" (p. 52). Leininger identified the characteristics of culture as (a) universal yet local or regional, (b) stable yet dynamic with the possibility of constantly changing, and (c) indicating how people live and yet may elude people's conscious thought. Culture signifies acceptable ways people have lived and managed the changes they experience in their environment. Furthermore, Leininger noted, "no two cultures are precisely the same" (p. 54). Loftin et al. (2013) noted the possible impact of culture on "behavior emotion, and lifestyle" of the people (p. 2). Sherman and Eggenberger (2008) identified several cultural transitional needs of nurses from other countries that may be summarized as societal, hospital professional nursing, and individual cultures (see Figure 2).

The healthcare environment in the U.S. is made up of diverse people and cultures. Hart and Mareno (2013) observed that both the U.S. population and the registered nurse workforce are growing more diverse. According to the U.S. Census of 2011, there is a 9.7% population growth in many of the ethnic groups that make up the U.S. population. This 9.7% growth has been further categorized by its cultural makeup: Asian (43%), Hispanic (43%), Native Hawaiian/Pacific Islander (35.4%), American Indian/Alaska (18.4%), Black/African American

(12.3%), and White 5.7% (Hart & Mareno, 2013, p. 2224). Therefore, incorporating cultural understanding of each patient's unique perspective becomes essential for positive nursing care (Hart & Mareno, 2013; Spector, 2004).

**Leininger's Culture of Care Theory (CCT).** Leininger (2002) called attention to the relationship between cultural understanding and care in her seminal research on Culture Care Theory. She posited that to achieve complete individualized nursing care of patients from various cultural backgrounds, the caregivers must understand and incorporate information about the patient's cultural influences. CCT offers a patient-focused pedagogy that addresses how to incorporate the patient's beliefs and cultural frames of reference in deciding care. Based on the changing profiles of U.S. patients, Leininger (2002) proposed a theory for a "culture of care" that defined the need for nurses to understand themselves and others in regard to cultural frames of reference, beliefs, and practices, suggesting, "Unquestionably new knowledge and practices were essential for nurses to function in a rapidly changing multicultural world" (p. 189). The culture of care's focus is on achieving optimal care for an increasingly culturally diverse patient population. Leininger (2002) noted, "This knowledge [CCT] is gradually transforming healthcare systems and changing nursing practices into relevant new ways of functioning" (p. 190). The current study sought to understand how operating within the CCT affects nurses from different cultures working within the U.S. culture and healthcare industry.

**Societal culture.** Culture affects how people behave. It provides a guide as to how realities are noted or interpreted. It also affects interactions with other people in their environment. As Yi and Jezewski (2000) have noted, culture is "a blueprint for thoughts and behaviors, and it is a dominant force in determining health-illness caring patterns and behaviors" (p. 722).

***Nurses from other cultures.*** Aboderin (2007), Jose (2011), and Kawi and Xu (2009), in their research, found that differences in culture affected how registered nurses from other countries experience nursing practice. In a phenomenological study of Nigerian registered nurses in the United Kingdom (UK), Aboderin (2007) noted that the nurses described the nature of work experiences in the UK as "routine, tedious and restricted" (p. 2243). The study also found that they had experienced a loss of professional and social status, compared to what they generally had in Nigeria before migrating to work in the UK.

Jose (2011) in a phenomenological study of 20 registered nurses in the U.S.—seven from India, five from Nigeria and eight from the Philippines—found that these nurses also experienced challenges in cultural adjustment, communication, and clinical practice skills while working in the U.S. healthcare environment. Before migrating, some had been influenced by television to believe that in the U.S., one can become financially comfortable doing less work. Jose concluded that foreign recruited registered nurses were frequently shocked and overwhelmed by the reality of living in the new environment. "Overall, study group members found the cultural diversity in the U.S. difficult to cope with and sometimes shocking" (Jose, 2011, p. 126). Jose (2011) suggested that there is value in being aware of differences in culture, which could impact the parties involved in health care. He noted, "understanding the needs of these nurses while they adjust to living and working in the USA is important to them, their employers and their patients" (p. 123).

In an integrative study to understand the challenges international registered nurses encountered, Kawi and Xu (2009) conducted a meta-analysis of existing research including "twenty-nine studies conducted in Australia, Canada, Iceland, UK, and the USA" (p. 174). Their analysis identified forces that either facilitated or created barriers for the registered nurses from

other countries as they settled in new healthcare environments. Some of the areas where the nurses experienced challenges included "language and communication difficulties, [as well as] differences in nursing practice and inequality" (p. 174). Kawi and Xu (2009) found that countering influences—education, support, self-determination and expression, as well as professional work environment—aided the adjustment process for these nurses.

Parrone et al. (2008) identified the "7Cs of cultural change . . . competency, communication, consistency, cooperation, customs, conformity, and courage" (p. 3). They suggested that the "7Cs" represent the various layers of culture foreign-born registered nurses have to navigate through daily as they are working in the U.S. healthcare system. They concluded, "The foreign nurse will encounter many barriers and practice problems no matter his/her level of skill" (Parrone et al., p. 3).

Ea (2008) studied the acculturation process of foreign registered nurses and provided some recommendations to address the challenges of acculturation. According to Ea (2008), there seems to be no other way for foreign registered nurses to go through the acculturation process than to directly experience the challenges in communication, an alien work environment, and professional responsibilities, as well as the activities of daily living and how personal and societal values are observed. Ea (2008) concluded that the acculturation process is comprised of three phases: "initial, conflict and adaptation" (p. 3). The process varies at each phase based on interactions that occur when a registered nurse from one culture encounters a different culture. Ea found that after the initial and conflict phases, there was an attempt by the registered nurse to understand and make meaning out of the new experience. If he or she is able to make sense out of the experiences, then positive adaptation generally occurs (Ea, 2008).

A phenomenological study of the lived experiences of nine Chinese registered nurses by Xu et al. (2008) found that their limited knowledge of the dominant U.S. culture was an impediment to their ability to effectively integrate into the society. Xu et al. described the adaptation process experienced, noting that when integration did not occur, the Chinese registered nurses described feeling a sense of isolation due to their inability to participate in simple conversations that may have alleviated the challenging situations. The nurses in the study described feeling discriminated against by some of the people they encountered in their daily activities of at work "including patients, nurses, and supervisors" (Xu et al., 2008, p. E40). Though the study was limited to Chinese registered nurses working in the U.S. healthcare industry, the findings provide valuable insights to further understand the experiences of registered nurses from other countries.

Prior research on the acculturation of foreign-born Japanese registered nurses working in Australia suggests that there is a staged process each Nigerian registered nurse moves through to become effective within the U.S. healthcare system (Kishi, Inoue, Crookes, & Shorten, 2014). This process consists of three phases: seeking, acclimatizing and settling [SAS]" (p. 186). Additionally, research Xu, Gutierrez & Kim (2008) and Parrone et al. (2008) has identified the challenges nurses from diverse cultures experience in providing care to patients from diverse cultures such as Chinese, Filipino, and Nigerian cultures suggesting that registered nurses need to adapt to a range of cultural needs to provide appropriate care based on the patient's cultural background (Leininger, 1990). Registered nurses are expected to enact the general standards of care about how to speak to a patient, maintain appropriate distance, use of touch as a caring tool, and how to instruct the patients about the care they receive, each within the context of the patient's culture.

Studies have suggested that some agencies interpret the lack of knowledge of cultural competency as a source of healthcare disparity in society (Engebretson et al., 2008; Spector, 2004). According to Engebretson et al. (2008), there is "a lack of conceptual clarity of cultural competence" (p. 174). In two studies, Edwards and Davis (2006) as well as Hart and Moreno (2013) noted that the challenges of caring for patients in the U.S. derives from language barriers, lack of cultural knowledge, and training for the nurses, as well as the inability of the registered nurses to comprehend and apply the different cultural specifications in the work environment. Hart and Moreno (2013) found that the inability to incorporate some aspects of the dominant culture into the patient care process seems to create practice challenges for most of the registered nurses from other countries.

Studies have indicated that several care issues arise as a result of differences in culture (Aboderin, 2007; Hart & Mareno, 2013; Judd, 2013; Magnusdottir, 2005). According to the scholars, culture determines people's behavior. It provides a guide to how realities are noted or interpreted. It also affects the interactions of people in their environment (Leininger, 1990). As Yi and Jezewski (2000) noted, culture is "a blueprint for thoughts and behaviors, and it is a dominant force in determining health-illness caring patterns and behaviors" (Yi & Jezewski, 2000, p. 722). Given the above research, it is important to understand the cultural background of the Nigerian registered nurses and how they interact with the patients from diverse cultures, that is the purpose of this study.

***Differential treatment and microaggression.*** While most people come from other cultures to pursue their dreams, they may also encounter some experiences that are considered discriminatory. Part of the documented history of the U.S. culture is that people receive differential treatment due to some personal attributes that seem different from those of other

members of society, such as the color of their skin or where they come from (Sue et al., 2007). Rocco, Bernier, and Bowman (2014) observed that differential treatments seem to exist based on factors like race, gender, and other visible physical identities. They noted that race plays a significant role in the policies and protocols in the workplace, which can create an unequal impact on some of the employees (Rocco et al., 2014).

Due to subjective reports of negative impacts on those who experience differential treatments in their lives and the dynamic nature of what constitutes differential treatments as a result of difference in race or ethnicity, Sue et al. (2007) provided possible working definitions of what people experience in their daily lives to help determine the effects of such experience on the victims' lives. Whereas many differential treatments seem to have been based on what is considered racism, Sue et al. noted that racism has transformed from blatant hurtful actions and obvious discriminatory acts to what is now considered racial microaggressions.

*What microaggressions are*. Microaggressions are defined as "brief, everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group. … often unconsciously delivered in the form of subtle snubs or dismissive looks, gestures, and tones" (p. 273). Similarly, Huber and Solorzano (2015) noted that microaggressions are "a form of everyday racism used to keep those at the racial margins in their place. They are (a) verbal and non-verbal assaults directed toward People of Color [POC], often carried out in subtle, automatic or unconscious forms" (p. 223). Mapedzahama, Rudge, West, and Perron (2012) also noted that a microaggressions "entails the mundane [activities] and is 'routinely created and reinforced through everyday practices'" (p. 156). All the scholars seem to agree that microaggressions are presented in subtle, unconscious manners. Sue et al. (2007) also provided a broader definition of racial microaggressions as:

> brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group. They are not limited to human encounters alone but may also be environmental in nature. (p. 273)

Types of microaggressions. Sue et al. (2007) identified three types of racially based microaggressions, namely microassault, microinsult, and microinvalidation. Each type articulates the nature of microaggressions to lend substance to the negative experience of the victim. *Microassault* refers to the "explicit racial derogation characterized primarily by a verbal or non-verbal attack meant to hurt the intended victim through name calling, avoidant behavior, or purposeful discriminatory actions" (p. 274). Next is *microinsult,* "characterized by communications that convey rudeness and insensitivity and demean a person's racial heritage or identity. … represents subtle snubs, frequently unknown to the perpetrator, but clearly convey a hidden insulting message to the recipient of color" (Sue et al., 2007, p. 274). *Microinvalidation* is the third type of microaggression "characterized by communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color" (Sue et al., 2007, p. 274).

Many researchers have noted that microaggressions can impact the professional growth and health of the victims negatively, as well as the organization over time. Offermann, Basford, Graebner, DeGraaf, and Jaffer (2013), O'Keefe, Wingate, Cole, Hollingsworth, and Tucker (2015), and Sue et al. (2007) noted the cumulative impact of microaggressions on the health and well being of the victims and their places of work. Numerous studies have suggested that differences in culture affect how registered nurses from other countries experience nursing practice in the healthcare industry (Aboderin, 2007; Jose, 2011; Kawi & Xu, 2009). According to Sherman and Eggenberger (2008), registered nurses from other countries encounter various

professional, educational, work, and general societal culture challenges. Nichols and Campbell (2010) identified similar challenges for nurses from other countries hired to work in United Kingdom.

**Summary.** This stream of theory, research, and practice related to culture highlighted the understanding of the various layers of culture in the U.S. healthcare system. It was noted that such understanding is key to comprehending culture's influence in nursing practice of the registered nurses from other countries and their lived experiences while working in the U.S. healthcare system. Based on the findings of the studies cited above, adjusting to a new work environment involves a great deal of time and effort. Thus, this calls for comprehensive support for registered nurses from other countries such as Nigeria. The role of culture is equally important in understanding the lived experiences of Nigerian registered nurses working in the U.S. healthcare system. Like registered nurses from other countries, those from Nigeria tend to interpret their lived experiences through the lens of the culture in which they grew up. However, learning the new culture in which they now work is central to successfully practicing nursing in the U.S. healthcare environment.

**Communication Differences**

Communication in healthcare is a medium through which healthcare givers professionally present what they think is worthy of sharing with other individuals. Amaritei (2013) defined communication as the process for "shar[ing] some information, an idea, a feeling, an opinion" (p. 279). Xu et al. (2012) added to the definition of communication as "a reciprocal process between at least two people of sending a message and interpreting it correctly through both verbal and nonverbal means" (p. 292). Communication in nursing practice impacts relationships between the nurse, patients, and their families as well as other healthcare providers.

Communication has been identified and is well documented in the literature as a challenging factor in nursing practice for nurses from other countries who are working in the U.S. healthcare industry (Boykins, 2014; Kawi & Xu, 2009; Lum, Dowedoff, Bradley, Kerekes, & Valeo, 2015; Shen, Xu, Bolstad, Covelli, Torpey, & Colosimo, 2012; Smith & Ho, 2014; Xu et al., 2010; Xu et al., 2012; Yahes & Dunn, 1996). Communication seems to permeate all aspects of nursing practice standards including patient-centered care, inter-professional collaboration, and informatics (Boykins, 2014). Boykins (2014) suggested that communication is vital in achieving safe and patient-centered care. "Patient centered-care is care based on a partnership between the patient, their families, and the healthcare provider that is focused on the patient's values, preferences, and needs" (p.40). Registered nurses from other countries who are working in the U.S. healthcare environment may encounter communication challenges including not being able to share their related knowledge or completely comprehend the healthcare information being communicated to them (Yahes & Dunn, 1996).

Nurses communicate as a means of advocacy for the patients and their families as well as to achieve healing; this is known as therapeutic communication (Potter & Perry, 2005). Boykins (2014) noted, "The nurse continuously advocates disease prevention, wellness, and promotion of healthy lifestyles" (p. 41) as part of providing professional nursing care. Apart from sending and receiving important messages regarding patient care, communication serves the purpose of helping the nurses "meet legal, ethical, and clinical standards of care" (Potter & Perry, 2005, p. 424).

Registered nurses from other countries working in U.S. healthcare are expected to understand the norms of verbal and non-verbal communication including eye contact, personal space, and touch, as well as their significant roles in human interaction (Maier-Lorentz, 2008).

Yahes and Dunn (1996) also noted that the corollary effect of ineffective communication opens the door to liability issues and challenges professional credibility.

In a mixed method study of nurses participating in a residency program to aid acculturation of nurses from other countries at a hospital with 864 beds in Texas, communication difficulties were identified as one of the challenges the nurses faced (Smith & Ho, 2014). Similarly in a cross-section study of seven directors of healthcare agencies comprising acute care, long-term care, rehabilitation care, and mental healthcare, and employing about 80 nurses from other countries, Yahes and Dunn (1996) found that six of the seven agencies identified that registered nurses from other countries needed improvement on communication skills noting, "The model addressed cultural variance related to: verbal style, non-verbal communication characteristics, culturally determined gender roles and assertive behavior" (p. 121). Yahes and Dunn suggested that foreign registered nurses had issues with verbal communication in speech behaviors, voice projection, pitch, mechanics, and lack of what they called comprehensive signals. Kawi and Xu (2009) noted that registered nurses from other countries experienced problems with non-verbal behaviors, pronunciation, accent, terminologies, and understanding the local jokes.

Nurses exchange information with patients to develop plans of care to suit each patient's needs. Communication is interwoven with the norms and layers of culture and central to nursing practice (Potter & Perry, 2005). Chandra and Willis (2005) suggested that communication offers a means of sending and receiving pertinent information regarding patient care and other professional development processes. Yahes and Dunn (1996) recognized that registered nurses are capable of sending verbal and non-verbal messages that may heal or harm the patient.

Beyond verbal communication, non-verbal communication can greatly influence how well a registered nurse cares for the patient. As Maier-Lorentz (2008) observed, "Non-verbal cues play a vital role in conveying messages, and these may vary considerably among different cultures" (p. 38). Some frequently used non-verbal communication behaviors in the U.S. can become sources of miscommunication if not fully understood by registered nurses from other countries (Engebretson et al., 2008; Potter & Perry, 2005). Eye contact, touch, silence, space, and distance and health beliefs are usually cues registered nurses use in the patient care process (Potter & Perry, 2005). Yet these behaviors can mean different things to people from different cultural backgrounds. Maintaining eye contact while speaking to someone is considered a sign of confidence in the U.S. culture (Spector, 2004); but in other cultures, such behavior can be interpreted as rude or disrespectful (Maier-Lorentz, 2008).

Therapeutic touch in nursing is considered a valuable non-medical approach to relieve anxiety and discomfort, whereas some cultures prohibit such intervention (Potter & Perry, 2005). Silence can be misinterpreted as not acknowledging the patient when actually in nursing practice it may indicate being empathic in a given difficult situation (Potter & Perry, 2005). Thus, maintaining appropriate space-distance during patient care becomes a crucial aspect in appropriate patient care. What is considered appropriate interpersonal distance or space varies by culture. Patients' health beliefs also affect how they receive care (Spector, 2004).

Boykins (2014) stated, "Effective communication is the creation of meaning in communication in which patients and healthcare providers exchange information so that patients are able to actively participate in their care" (p. 40). Communication in nursing practice involves intrapersonal, interpersonal, transpersonal, small group, and public levels of communication during patient care (Potter & Perry, 2005, p. 427). The development of competency on each

level of communication helps the nurse to effectively deal with patient care situations. The effectiveness of the various levels of communication depends on how well the nurse is able to master the basic elements involved in communication process.

**Summary.** The research, theory, and practice about the importance of communication are documented as a vital link to many aspects of nursing practice leading to safe patient care. Many studies as cited above support that nurses from other countries are challenged in their professional nursing practice due to lack of, or limited understanding of the variations and nuances of communication. It is important to understand the perceptions and opinions about communication and its implications in nursing practice from Nigeria registered nurses.

**Clinical Competency (CC)**

Though there is much reliance on nursing competency to evaluate the ability of a registered nurse to provide safe care, there seems to be an unclear definition of clinical competency (Allen et al., 2008; Axley, 2008; Cronenwett et al., 2007; Edwards & Davis, 2006; Redman, Lenburg, & Hinton Walker, 1999; Wolcott, Llamado, & Mace, 2013; Yanhua & Watson, 2011). Axley (2008) noted, "the lack of a clear definition of competency in nursing has left administrators, educators, and practice-based nurses in need of an established theoretical definition" (p. 215). According to Axley (2008), the term competency is widely used in the U.S. in health care because it provides a strategy for the nursing profession and other healthcare givers to redefine practice to keep pace with the changes in healthcare. Clinical competency seems to form the foundation of nursing practice. Axley noted, "Implementation of new practices requires nurses who can demonstrate competency in clinical practice" (p. 215).

"There is a wide discrepancy around the world with regard to standards for nursing education qualification, and scope of nursing practice" (Wolcott et al., 2013, p. 263).

Understanding "the U.S. scope of nursing practice, which varies significantly from that of other countries" has been identified as one of the challenges registered nurses from other countries encounter (Smith & Ho, 2014, p. 31). Registered nurses from other countries are seemingly challenged when they are confronted with learning a set of competencies that could be different in the next location of work.

Yi and Jezewski (2000) observed that Korean nurses indicated practice difference mainly around the role of families in patient care and the division of labor and role of the nursing assistant and unit secretaries in health care. Wheeler, Foster, and Hepburn (2013) noted that the internationally educated nurses (IENs) from Southwest Asia and Sub-Saharan Africa expressed that nursing skills remain functionally the same regardless of location of practice. Lin (2014) indicated that Philippine nurses perceived differences in practice around nursing scope of practice, technology, and legal implications.

Clinical competency in nursing can be considered an umbrella term. It seems to connote demonstrated behavior indicating the ability to perform skills that are considered standard protocols (Wu et al., 2015). There are several levels of nursing practice, each with defined sets of competencies. Allen et al. (2008) noted that clinical competency and its evaluation could be very challenging given the diverse range of nursing practice, including clinical practice, research, education, and informatics.

Edwards and Davis (2006) conducted a survey study of 3,205 nurses from 30 countries using a clinical competency tool. The survey measured the expected initial clinical skills a registered nurse should posses to provide "safe and effective nursing practice" (p. 265). According to Edwards and Davies, 77 clinical competencies required of nurses were identified and categorized into nine groups: (a) performing treatment, (b) managing pain, (c) administering

medication, (d) performing nursing procedure, (e) managing patient care, (f) performing assessments, (g) using nursing processes for care planning, (h) managing cardiac patients, and (i) using technology. Each of the competency groups has a list of skills to certify that a nurse can perform said competency.

Allen et al. (2008) noted, "professional nursing competency can be viewed as the application of knowledge and skills necessary for the practice role, within the context of public health, safety, and welfare [of care receiver]" (p. 81). The U.S. healthcare industry can be very dynamic and nursing practice changes to keep pace. Axley (2008) noted, "Change is constant throughout nursing and healthcare practice standards because of important findings in research and improvements in technology" (p. 215).

In light of keeping nursing competency current, Allen et al. (2008) suggested, "competency components must reflect the ongoing application of knowledge, decision-making, psychomotor, and interpersonal skills expected of licensed nurses" (p. 82). The dynamic nature of healthcare and the need for the nursing profession to keep pace with the changes is echoed by the recent amendment of the Nurse Practice Act (NPA) in California, which further clarifies the nurses' role in light of the changes in healthcare (California Board of Registered Nursing, 2015). "The Nurse Practice Act is a set of state laws that govern certain aspects of nursing practice" (Mikos, 2004, p. 20). The NPA establishes the scope of nursing practice, defining the roles and responsibilities of the nurse, licensure requirements, and how to manage discipline issues. The state BRN has the legal administrative duties to interpret and implement the NPA relating to nursing competencies for safe care (Mikos, 2004).

The reliance on clinical competence as the yardstick to measure quality and safe patient care to minimize the death of patients as a result of medical errors has propelled the need for the

Joint Commission on Accreditation of Healthcare organizations to require healthcare in the U.S. to provide evidence to "show a process is in place to assess, validate, track, and maintain or improve the competency of their staff on an annual basis" (Axley, 2008, p. 214). Competency seems to imply the ability to acquire knowledge and demonstrate its application in a given profession like business, education, law, or nursing (Axley, 2008). Although there seem to be divergent views about nursing competence, there appears to be great effort put into defining activities that will identify a qualified nurse who provides safe and patient-centered care (Cronenwett et al., 2007; Yanhua & Watson, 2011).

In a seminal effort to actualize some of the recommendations presented by the Institute of Medicine (IOM; 2003) regarding safe patient care, Cronenwett et al. (2007) developed what is known as "Quality and Safety Education for Nurses (QSEN)" (p. 122). QSEN addresses a nurse-friendly approach to achieve the six competencies (patient-centered care, teamwork and collaboration, quality improvement, safety, informatics, and evidence-based practice) identified by the IOM report. "The goal was to describe competencies that would apply to all registered nurses" (p. 124). Cronenwett et al. went on to define specific sets of actionable statements under the categories of "knowledge, skills, and attitudes (KSA) for each competency" (p. 122) in the building of nursing competencies. The scholars think that KSA will provide a framework for the nursing profession to be used in a variety of circumstances.

In addition to the development of KSA as the framework that drives the six competencies mentioned above, Dolansky and Moore (2013) think it is important for nurses to be aware of the systems that support them in their daily practice to function better. They present that the nurses would also need to understand the KSA about the healthcare system. They defined system thinking as "the ability to recognize, understand, and synthesize the interactions and

interdependencies in a set of components designed for a specific purpose" (p. 4). Critical thinking combined with the understanding of system thinking seems very fundamental to nursing practice. Dolansky and Moore (2013) further noted that the combined skills would support nurses in "engag[ing] in better problem-solving, priority setting, delegation, interactions and collaborations, decision making, and action-taking" (p. 4).

The nursing process is used by the nurse to obtain pertinent information to make appropriate patient care decisions. It provides a systematic framework for determining nursing care and its effectiveness based on the resolution of the identified patient's problem (Lea, Anema, Briscoe, & Allie, 2001). According to Potter and Perry (2005), the nursing process is an organized way to gather and synthesize information from various sources about a patient. Lea et al. (2001) consider the nursing process as the "foundation of clinical decision making for nursing practice" (p. 3).

**Cultural competence**. Many, if not most, of the registered nurses from other countries are challenged to learn about the specific needs of diverse population groups within U.S. society (Engebretson et al., 2008). Nursing education has generally been designed to meet the requirements for addressing the issues in the mainstream culture (Maier-Lorentz, 2008). Issues about death and dying, patient advocacy, patients' rights and privacy, as well as protection are traditionally addressed in the U.S. nursing curriculum but may not have been addressed in curricula in other cultures. (Bola et al., 2003). Additionally, confidentiality, managing patient sexual orientation, abuse, religious preference, and RN-MD collaboration are all parts of the training that nurses acquire (Sherman & Eggenberger, 2008).

Zizzo and Xu (2009) conducted a systemic review of 20 post-hire transitional training programs available for registered nurses working in the U.S. healthcare industry. Their findings

indicated that training programs varied in structure based on the needs of the nurses from diverse countries as well as the patient population under care. They concluded that there is a need for evidence-based professional development programs for registered nurses from other countries to assure competency and patient safety.

According to Maier-Lorentz (2008), a nurse is regarded as culturally competent if he or she has the ability to acquire the knowledge about other cultures and incorporate such knowledge into holistic nursing care of the patients. The tenets of holistic care as the core of nursing practice incorporate caring for the patient's "physical, psychological, social, emotional, and spiritual needs" (Maier-Lorentz, 2008, p. 37). Furthermore, Maier-Lorentz (2008) noted that cultural competence can be defined based on the ability of the nurse to: (a) understand cultural differences; (b) be sensitive to issues about culture, race, ethnicity, gender, and sexual orientation; (c) have efficacy in communication skills and cultural assessment; and (d) be knowledgeable about the health practices of different cultures.

**Regulation requirements**. The U.S. healthcare system is dynamic and the rules of care change often (Windle, 2008). U.S. hospitals operate by the rules set by the regulatory agencies. The foundation of rules and regulation focuses on patient care, patient protection, and reimbursement of healthcare costs (Betancourt et al., 2005; Donnelly, 2000; Fox & Abrahamson, 2009; Judd, 2013; Xu et al., 2010). Regardless of where registered nurses are educated, they are held accountable for the policies and procedures, regulatory requirements, inter-professional practice, hospital routine process, nursing, and medical procedures (Parrone et al., 2008).

Generally, healthcare ethics guide caregivers to provide non-discriminatory care to benefit the patient. As noted by Engebretson et al. (2008), "Ethical principles regarding medical nonmaleficence and beneficence entreat health care providers to avoid harm" (p. 173). Several

customs are unique to the U.S. (Donnelly, 2000; Xu, 2010). The U.S. culture assumes that individuals are well informed, able to make their own decisions, and take responsibility for their actions. A legal authorization is required for anyone other than the patient to make a decision about care (Bola et al., 2003).

While the debate on care and culture continues, Engebretson et al. (2008) attempted to find objective ways to put the concept of cultural care into practice. This has become very important as several new standards and regulations are being developed to address the issues of healthcare disparity as a result of race and ethnicity. Identifying ways to make cultural competency applicable to professional health care will be useful so all care providers will recognize the needs that emerge from cultural diversity by caregiver and patient. This may also prevent erroneous ethical and legal implications. To support the issue of learning cultural care competence by healthcare providers, Engebretson et al. (2008) applied the concept of cultural competency continuum and evidence-based practice to provide practical ways to incorporate cultural care competence into healthcare. Some registered nurses may not be aware of the details of the divergent views and frameworks guiding nursing competency. Registered nurses from other countries like Nigeria maybe unaware of the intricacies of nursing competency, yet as registered nurses, they are responsible for the outcome.

**Summary.** This stream provides insight into what nursing competency may entail. There seems to be relevant divergent views and approach to utilizing nursing competency. The healthcare industries and the related regulatory agencies seem to rely on the available competencies to measure the qualification of nursing care providers and quality of care. As noted above, the IOM in its 2003 report and recommendations identified six universal competencies (patient-centered care, teamwork and collaboration, quality improvement, safety,

informatics, and evidence-based practice) for all healthcare providers to provide safe patient care. Cronenwett et al. (2007) developed quality and safety education for nurses (QSEN), which provide actionable sets of knowledge, skills, and attitudes (KSA) to solidify required competency. In addition to developing KSA, Dolansky and Moore (2013) noted the need to develop critical thinking and system thinking abilities as a necessary framework to utilize nursing competencies. There is a need for evidence-based professional development programs for registered nurses from other countries to assure clinical competency and patient safety.

## Summary

Chapter 2 explored the theory and principles of culture, communication, and clinical competency fundamental to nursing practice. This chapter discussed related research about the underlying principles of culture, communication differences, and clinical competencies requisite for registered nurses from other countries working in the U.S. healthcare environment. The literature seems to support that nurses from other countries working in the U.S. healthcare industry encounter challenges in all three areas.

A basic understanding of nursing competencies for communication and nursing process is critical to successful nursing practice (Sherman & Eggenberger, 2008; Xu, 2010; Xu et al., 2008). In addition, nurses are required to practice nursing within hospital policies and procedures. They are also expected to practice nursing in collaboration with the other healthcare givers.

As noted in Chapter 1 and emphasized throughout Chapter 2, culture, communication, and clinical competencies are the 3 Cs guiding nursing practice in this study. Foreign-born registered nurses hired to work in the U.S. will be required to satisfy the required standard of practice (Kishi et al., 2014; Xu, 2010; Xu et al., 2008). The 3 Cs and their components provide a

foundation to guide this study. In other words, they are the lenses through which the researcher explored the lived experiences of Nigerian registered nurses working in the U.S. healthcare system across Northern California.

# Chapter 3: Research Methodology

## Introduction

Few studies have been conducted on the lived experiences of Nigerian registered nurses working in the U.S. healthcare environment (Adeniran et al., 2008; Jose, 2011). Available literature indicates that registered nurses from other countries have encountered some challenges while working in the U.S. healthcare environment (Adeniran et al., 2008; Donnelly, 2000; Hart & Mareno, 2013; Jose, 2011; Xu, 2010; Yi & Jezewski, 2000; Zizzo & Xu, 2009). The purpose of this qualitative phenomenological research design was to explore the lived experiences of the Nigerian registered nurses working in the U.S. healthcare environment in Northern California.

The following research questions guided this study.

1. How do the Nigerian registered nurses describe their challenges working in the U.S. healthcare environment in Northern California?
2. How do the Nigerian registered nurses describe the effect of challenges on their personal and professional lives?
3. What are the perceived attributes for success identified by the Nigerian registered nurses working in the U.S. healthcare environment in Northern California?

## Research Design and Rationale

This qualitative phenomenological research was conducted from the stance that the meaning of the lived experiences of Nigerian registered nurses is socially and culturally created. Among other definitions, phenomenology is a methodology that uses an in-depth interview to explore participants' experiences and to find meaning in their lived experiences (Bloomberg & Volpe, 2012; Creswell, 2012; Merriam, 2009). As suggested by Maxwell (2013), "it is important

to recognize that the meanings, and beliefs, and so on of the participants in your study are a major part of what you want to understand" (p. 30). This researcher used a social constructivist perspective in this study. In this context, the use of this stance entailed paying close attention to "the views, values, beliefs, feelings, assumptions, and ideologies of individuals [in an environment] than in gathering facts and describing acts" (Creswell, 2012, p. 429).

According to Bloomberg and Volpe (2012) and Merriam (2009), phenomenological methodology allows the researcher to be a part of the study by interacting with the participants to understand the meaning of their experiences. The researcher acknowledged and bracketed her thoughts or beliefs based on her tacit experiences that may have influenced data collection and analysis to allow for interpretation of the data emerging from the field research through the perceptions and experiences of the participants in the study (Merriam, 2009). Although the researcher may have feelings or experiences similar to those of the participants, all beliefs, assumptions or prior knowledge the researcher holds regarding the phenomenon were temporarily set aside to allow for a clear and complete understanding of the participants' perceptions and opinions (Merriam, 2009).

Qualitative research design allows the researcher to seek clarity about how people perceive and value the activities in which they are involved (Roberts, 2010). This research falls into two of the many noted reasons qualitative research is done: (a) "to uncover and understand what lies behind any phenomenon about which little is known" and (b) "to gain novel and fresh understanding of things about which quite a bit is already known" (Roberts, 2010, p. 143). In this study, the data highlight the perceptions and opinions of Nigerian registered nurses working in U.S. healthcare environment in Northern California.

Using phenomenological design to address the research questions "seeks to unveil the description, meaning and essence of the experience" (Salmon, 2012, p. 4). Phenomenological research design allows for exploring and capturing the lived experiences of the participants (Moustakas, 1994; Russ-Eft & Preskill, 2009). The researcher provided a setting for the participants to express their experiences, which were then interpreted for meaning within the parameters of the study. While the researcher was a part of the study based on past experience, her experiences as noted earlier, were bracketed at the time of data collection and analysis. The information provided by the participants is the core of a phenomenological method (Moustakas, 1994). The researcher, therefore, has the responsibility to interpret the information based on the account of their experiences. According to Moustakas (1994), "The understanding of meaningful concrete relations implicit in the original description of experience in the context of a particular situation is the primary target of phenomenological knowledge" (p. 14). It is believed that studying the perceptions and opinions of Nigerian registered nurses in Northern California may provide valuable information on their lived experiences that can be utilized for future training and education of nurses on culture, communication, and clinical competencies.

## Site and Population

### Population Description

This study used a purposeful sampling method for data collection (Creswell, 2012). The sample in this study consisted of male and female registered nurses who were either trained in a foreign school of nursing or in a school of nursing in the U.S. and who self-identified as Nigerians working in the U.S. healthcare environment in Northern California. To participate in this study, the registered nurses must have passed the NCLEX-RN® and worked for at least one year in the U.S. healthcare industry in Northern California.

The participants were also recruited via snowball methods, with referrals for identifying participants coming from those participants purposely identified (Russ-Eft & Preskill, 2009). The researcher interviewed 16 participants: a minimum of eight (8) self-identified Nigerians who received their initial nursing training outside the U.S. and the remaining (8) participants received their training either from within the U.S. or foreign trained.

### Site Description

There was no single site for this study. The nurse participants worked in healthcare facilities across Northern California. The interviews were conducted via face-to-face interaction at a location convenient for the participants.

### Site Access

As previously noted, the site for this study was non-specific. As a result, there was no anticipated access problem.

## Research Methods

### Description of Methods Used

It has been observed that the choice of study design and research questions influences the data collection method (Merriam, 2009; Moustakas, 1994; Russ-Eft & Preskill, 2009). Salmon (2012) noted that phenomenological study process provides a "novice nurse researcher" a tool to present the meaning from information gleaned from the lived experiences of the participants, and "it enables researchers to understand the life experiences of others in relation to health and quality of life" (Salmon, 2012, p. 5).

In line with the phenomenological research design, this study used individual interview, researcher journaling, and field notes as well as review of related artifacts (Merriam, 2009; Moustakas, 1994; Russ-Eft & Preskill, 2009) to collect data about the lived experiences of 16

Nigerian registered nurses. As Maxwell (2013) noted, "This strategy reduces the risk that your conclusions will reflect only the biases of a specific method, and allows you to gain a more secure understanding of the issues you are investigating" (p. 102). Triangulation (gathering of data through different methods), therefore, contributes to the trustworthiness of the research method and findings (Merriam, 2009).

**Interviews.** Interviews allow the researcher and the participants to interact during data collection to present in-depth perceptions and opinions of their lived experiences. Semi-structured individual interviews are among the "means for collecting rich, qualitative information" (Russ-Eft & Preskill, 2009, p. 214). This allows participants an unhindered opportunity to tell the human side of the story that may not be gathered with structured closed-end questionnaires or "hard numbers" (Russ-Eft & Preskill, 2009, p. 362).

Individual interviews are one of the main methods of data collection in a qualitative study (Creswell, 2012). In this phenomenological design study, a semi-structured interview was utilized to collect data from the Nigerian registered nurses about their lived experiences working in the U.S. healthcare environment in Northern California. In addition, the researcher kept a journal, applicable artifacts, and field notes during the interview (discussed in the following section).

***Instrument description***. In this study, an 18-item questionnaire was used to conduct an in-depth individual, semi-structured interview. The protocol is divided into two sections: the first section contains questions to gather demographic data from each participant; the second portion of the interview asked open-ended questions that allowed the participants to provide information about their lived experiences (see Appendix A). Probes of the responses allowed for understanding the deepening richness of their lived experiences.

***Participant selection.*** Study announcement was made via a local community email and participants were selected by purposeful sampling. The selection criteria included: (a) participant self-identified as a Nigerian registered nurse who attained his or her nursing credential in studies within or outside the United States, (b) participant was a registered nurse working in healthcare environment in Northern California, and (c) participant worked for at least one year as a registered nurse. Participants were selected based on being first responders to the announcement. Snowball sampling was used to recruit participants.

***Identification and invitation.*** After the initial announcement (see Appendix B), participants who were willing to participate in the study were invited to contact the researcher to arrange for an interview. Upon expression of interest, the participants were required to review and verbally consent to the research process (see Appendix C). The consent form provided explanation for the study process, privacy, and confidentiality as well as the participants' right to withdraw from the study at any time without penalty. As previously mentioned, the researcher relied on the snowball method to identify and invite potential participants.

***Data collection***. Interviews lasted for 60 minutes. The individual interview sessions were conducted using the face-to-face approach and were tape-recorded using two devices, transcribed verbatim, and coded for analysis and to identify the emerging themes. Personal identification of participants was protected by the use of pseudonyms. For security, the data were stored on a drive without Internet access and with backup copies.

**Journal.** Through journaling, the researcher was able to write about activities before and during the interview process. Information recorded contributed to data analysis and coding (Bloomberg & Volpe, 2012).

***Instrument description***. This researcher kept a reflective journal to enhance the data collection process. Journaling also provided a tool for bracketing process for the researcher. The researcher's "internal dialogue" (Bloomberg & Volpe, 2012, p. 144) was captured and analyzed for proper coding. It helped provide a clear picture of the role of the researcher during the interview process and allowed the researcher to review the interview process and document some information that aligned with the recorded data (Merriam, 2009).

***Participant selection.*** All participants were notified during the informed consent process of this journaling activity. They were also informed that related notes would be made during the face-to-face interview sessions.

***Identification and invitation.*** After the initial announcement, participants who were willing to participate in the study were invited to contact the researcher to arrange for an interview. Upon expression of interest, the participants were required to review and verbally consent to the research process (see Appendix B). The consent form provided explanation for the study process, privacy, and confidentiality as well as the participants' right to withdraw from the study at any time without penalty.

***Data collection.*** The researcher maintained notes on the interactions with each participant, including observations made during the interview. This journal was maintained on an independent drive without Internet access.

**Field notes.** Field notes provide another form of data for the researcher. The notes talked about the environment, participants' behaviors, the setting, direct quotes, as well as researcher's comments (Creswell, 2012; Merriam, 2009). The use of various data gathering sources as noted earlier, provide more information that can enhance the data (Merriam, 2009).

***Participant selection.*** After the initial announcement, participants who were willing to participate in the study were invited to contact the researcher to arrange for an interview. Upon expression of interest, the participants were required to review and verbally consent to the research process (see Appendix B). The consent form provided explanation for the study process, privacy, and confidentiality as well as the participants' right to withdraw from the study at any time without penalty.

***Identification and invitation.*** The participants were notified during the informed consent process that related field notes would be taken during the face-to-face interview sessions.

***Data collection.*** During the interview process, the researcher took field notes using the template in Appendix C regarding the "events, activities, and people" (Creswell, 2012, p. 217).

**Artifacts.** Artifacts are items of record that may provide more information regarding the topic of study. All records obtained during data gathering that align with the interview may be categorized as artifacts. However, "data not gathered through interview" in the form of "documents" are considered as artifacts (Merriam, 2009, p. 140).

***Instrument description***. In this study, the researcher collected and kept record of applicable documents of all items provided by the participants that could enhance the information from the interview.

***Participant selection.*** All participants who participated in the interviews were asked to provide documents and artifacts that related to the support of their nursing career in the U.S.

***Identification and invitation.*** After the initial announcement, participants who were willing to participate in the study were invited to contact the researcher to arrange for an interview. Upon expression of interest, the participants were required to review and verbally consent to the research process (see Appendix B). The consent form provided explanation for

the study process, privacy, and confidentiality as well as the participants' right to withdraw from study at any time without penalty. Those who consented were invited to provide artifacts that related to the support of their nursing career in the U.S.

***Data collection.*** During the interview session, the participants were asked to provide any form of related artifact that could enhance the data collection process. Artifacts were analyzed and this information is provided

**Data Analysis Procedures**

As Merriam (2009) noted:

> Data analysis is the process of making sense out of the data. And making sense out of data involves consolidating, reducing, and interpreting what people have said and what the researcher has seen and read-it is a process of making meaning. (p. 175)

Furthermore, data analysis is the collation of all sources of information (memos, artifacts, field notes, etc.) from the interview. The coded data were categorized by themes as they emerged from the participants' experience, which reinforced the researcher's conceptual framework (Merriam, 2009; Moustakas, 1994; Saldaña, 2013). Data analysis and coding allow the researcher to categorize the available information to build the emerged themes (Russ-Eft & Preskill, 2009). The emerged themes were then utilized to make inferences regarding the research findings. The coding process was utilized to identify the themes, which informed the research questions. It is important to note that data coding is only a process leading to identifying the results of a study.

As Saldaña (2013) noted, "A theme is an outcome of coding, categorization, or analytic reflection, not something that is, in itself, coded" (p. 14). This researcher transcribed the raw data verbatim and performed data analysis from the various sources to reinforce the validity of

the results (Saldaña, 2013). Applicable first-cycle coding methods, as noted by Saldaña (2013) including Attribute, Structural, Descriptive, and In Vivo coding methods, were used in this study.

Attribute coding was used to document and analyze the data of this study. As Saldaña (2013) noted, this method of coding helps organize data from several study participants and various sources of data. Structural coding methods were used to organize the data from the semi-structured interview questions. "Structural coding is perhaps more suitable for interview transcripts" (Saldaña, 2013, p. 84). Descriptive coding is a coding method that is mostly used by researchers to analyze qualitative data gathered from various sources such as interviews, field notes, and journals as well as artifacts, as in this study (Saldaña, 2013). The In Vivo coding method is also a process used by researchers to describe information transcribed verbatim from raw interview data (Saldaña, 2013). Both forms of coding were appropriate for describing the data from this qualitative phenomenological research design. The second-cycle coding data were organized and categorized, and themes were identified. "The primary goal during Second Cycle coding is to develop a sense of categorical, thematic, from array of First Cycle codes" (Saldaña, 2013, p. 207).

**Stages of data collection.** A planned timeline for data collection follows.

Table 1

*Data Collection Timeline*

| Action | Dates |
|---|---|
| Committee review and approval | June 2015 |
| IRB approval | July 2015 |
| Interviews and transcriptions | August–September 2015 |
| Analysis of data | September–October 2015 |
| Drafting Chapters 4 and 5 | November 2015–May 2016 |
| Dissertation Celebration | May 2016 |

## Ethical Considerations

Polit and Beck (2004, 2009) observed that ethical considerations refer to the moral standards a researcher needs to consider in all stages of research design and methods. Scholars have noted that in every study or research, the researcher is expected to respect human dignity and the right for fair treatment and privacy (Creswell, 2012). Thus, in this study, proper IRB protocol from Drexel University was followed to protect participants' rights and privacy.

By definition, the IRB is "a committee of faculty who reviews and approves research so that the rights of humans are protected" (Creswell, 2012, p. 622). It is pertinent to note, therefore, that this study was designed to assure that the "researcher-participants relationship" (Polit & Beck, 2004, p. 76) was not abused. Thus, all data remain confidential. The Informed Consent was explained to the participants after which they verbally agreed to the document indicating their willingness to participate in the study. The informed consent explanation addressed the following: use of data, reporting of findings, data storage, and possible withdrawal

from the study without penalty. Any participant who wished to withdraw from the study may have done so at will at any time.

Findings from this study are reported using pseudonyms or in an aggregate form. The participants were informed that there was the possibility the data collected would be published in a professional journal for the purpose of learning. The IRB protocol at Drexel University was completed. During the study, data were maintained by the investigator on drives without Internet access. After completion of the study, data were housed and secured at Drexel University. They will be maintained for future use, and will only be destroyed when all publications related to the data collection are concluded. At that time, they will be destroyed.

## Summary

This chapter outlined and discussed the research method, research design, and data collection process. The phenomenological study design was identified as appropriate for this study. It has been observed that phenomenological study design allows the researcher and the participants to interact for the purpose of collecting data (Creswell, 2012). The purpose of this qualitative phenomenological research design was to explore the lived experiences of the Nigerian registered nurses working in the U.S. healthcare environment in northern California. Recorded interview protocols were used to gather information based on answers to the semi-structured questions. Additional data were also gathered using journal, artifact, and field notes. The raw data were transcribed verbatim, coded, and analyzed for themes to provide answers to the research questions. This chapter also described how the researcher provided privacy, confidentiality, and data security during the research process.

# Chapter 4: Findings, Results, and Interpretations

## Introduction

The purpose of this phenomenological study was to explore the lived experiences of Nigerian registered nurses working in the U.S. healthcare environment in Northern California seeking to understand the cultural, social, and educational challenges they face. This chapter describes the nurses who participated in this study and provides a discussion of the findings presented as themes and subthemes that are supported with thick, rich descriptions of the participants' experiences represented in their own words. The results and interpretation of the findings are discussed in the final section of this chapter.

## Participant Background

Sixteen self-identified Nigerian-born registered nurses who had practiced nursing for at least one year in a healthcare organization in Northern California participated in the study. Table 2 provides a demographic summary including information on the participants: (a) pseudonym, (b) gender, (c) degrees earned, (d) education location, (e) current healthcare work environment/department, and (f) length of practice in years.

Table 2

*Participant Demographics*

| Pseudonym | Gender | Degrees earned | Education location | Current work/ Specialty | Years of Practice |
|---|---|---|---|---|---|
| Amina | F | RN, BS, MSN | US | Hospital/Neonatal Intensive Care | 24 |
| **Chima** | F | RN, BA, MSN/MBA | US | Hospital, Managed Care | 19 |
| **Chioma** | F | RN, BSN | US | Hospital, Clinic | 3 |
| **Ndidi** | F | RN, BSN | US | Hospital, Acute Care | 4 |
| **Osita** | F | RN, ASN, BSN | US | Hospital, Acute Care | 13 |
| **Ozimma** | F | RN, ASN, BSN | US | Hospital, Rehabilitation | 1 |
| **Amara** | F | RN, ASN | US & Overseas | Hospital, Skilled Nursing | 5 |
| **Adamma** | F | RN, BSN | US & Overseas | Hospital, Acute Care | 25 |
| **Nkem** | F | RN, ASN, BA | US & Overseas | Home Health, Hospice | 12 |
| **Onyeka** | F | RN, ASN, BSN, MSN | US & Overseas | Hospital, Acute Care | 15 |
| **Aniete** | F | RN, BSN | Overseas | Hospital, Mental Health | 12 |
| **Otito** | F | RN, ASN | Overseas | Hospital, Juvenile Health | 28 |
| **Agu** | M | RN, ASN, BA | US | Hospital, Medical-Psychiatry | 8 |
| **Afam** | M | RN, BS, BSN | US | Hospital Intensive Care | 20 |
| **Ikenna** | M | RN, BS, MSN | US | Hospital Acute Care | 8 |
| **Nnam** | M | RN, ASN, BA, MSN | US & Overseas | Hospital Acute Care | 24 |

The 16 participants in this study included 12 females and four males. Two participants received all their nursing education overseas, five of the participants received their education in both overseas and US schools, and nine of the participants received all their education in the U.S. Regardless of where they were educated, all the participants in this study passed the NCLEX-RN® given by the California BRN.

In addition to their RN licensure, the participants earned various degrees in nursing including Associate's (ASN), Bachelor's (BSN), and Master's (MSN) degrees. Seven of the participants have other non-nursing degrees. The participants in this study had practiced nursing in various Northern California hospital environments and in different areas of healthcare specialties including acute care (medical-surgical, orthopedic surgery, telemetry, step-down), intensive care unit, maternal-child, insurance, juvenile health, skilled nursing, managed care, home health, clinic, hospice, mental health/psychiatry, and rehabilitation. The participants represented that their length of nursing practice in California ranged from one year to 28 years.

**Research Questions**

The following questions guided this research study.

1. How do the Nigerian registered nurses describe their challenges working in the U.S. healthcare environment in Northern California?
2. How do the Nigerian registered nurses describe the effect of challenges on their personal and professional lives?
3. What are the perceived attributes for success identified by the Nigerian registered nurses working in the U.S. healthcare environment in Northern California?

## Findings

The findings represented in this chapter emerged from analysis and coding of interview transcriptions. The data were transcribed verbatim, and artifacts and the researcher's notes were reviewed for triangulation with the data. In the first round of coding, the transcribed data were read and reviewed against the recordings and researcher's notes. Then the participants' transcribed responses to each of the interview questions (1-18) were grouped together for further analysis. In the initial coding process, responses to Question 1 were grouped together. The same

process was repeated for all the responses to all 18 questions. Next, the researcher reviewed all the transcripts using open coding to identify words or sentences relevant to the study. The researcher further used In Vivo coding to identify participant responses that were recurring and similar (Saldaña, 2013).

There were 28 similar words and phrases identified from across the responses. The repeating words, phrases, and responses were further grouped and this with the earlier analysis informed the themes and sub-themes that emerged. The four themes include: (a) influences to become a registered nurse, (b) developing professionally, (c) transitions experienced, and (d) responding to challenges. Each major theme is organized with several subthemes. Figure 3 offers a graphic summary of the four themes and sub-themes.


*Figure 3.* Themes and subthemes.

**Influences to Become a Registered Nurse**

This theme describes the driving forces that led participants to become nurses. Each participant told a story of how she or he decided to become a nurse. Participants readily and vividly verbalized how they made their choice. They described several factors that helped them in making the decision to choose this career: (a) liking to work with people, (b) providing care for those who are vulnerable, (c) personal life experiences, (d) family recommendation, or as a (e) result of economic needs and job opportunities. Detailed descriptions of these factors are discussed in four subthemes: (a) caring, (b) personal experiences, (c) job opportunity, and (d) family and friends' recommendations. Evidence of each is provided through the voices of the participants themselves.

**Caring.** This subtheme captures why some participants chose to be nurses. Six of the participants expressed that they liked working with and helping to provide care for people in vulnerable states, such as when people are sick. Ndidi stated, "I like working with people. I like helping." Similarly, Ozimma echoed, "I love dealing with human beings." Chima said, "It's a profession for me. I really love taking care of people." Onyeka echoed, " I felt this is where I belong to help out." Chioma similarly said, "I love taking care of people and we nurses take care of people." Amara stated that the profession that would "get me closer to people is nursing." Against the backdrop of the joy in working with people, Amina expressed that nursing allows for providing care for people who most need it. Nnam presented that being a nurse provided him "an opportunity for me to develop, promote health across the board and also learn more about healthy living and things relating to health." Using similar statements, these participants

described having the desire to care for others and work with people as their basis for becoming nurses.

**Personal experiences.** Some participants shared stories about how their life experiences influenced their choices to become nurses. Nkem talked about how nurses cared for her son when he was in the hospital for three months and how she decided that becoming a nurse was the best choice to return the gift of caring for her son.

> I think the nurses that cared for him, just the way they cared for him, took care of him, I'm like, oh my God I have to give something back. So that was . . . I said I have to give back. I want to give back to society for the way my son was cared for and he survived, . . . that is how I fell in love with nursing.

Chima recalled a personal experience while in Nigeria. She described how the care her mother received when she was ill gave her clear understanding about the value of being a nurse.

> I remember when I was in Nigeria my mother passed out, and I was young and I went to hospital with her, and I saw nurses wearing their uniform; it was something that you know, I was touched the way they took care of her so I didn't have to know what I wanted when I came here.

Onyeka remembered how she worked with her grandmother who cared for pregnant women and their newborns. She recalled how her grandmother nurtured these patients.

> I always helped her, and the way she nurtured those women when they [were in] labor, you know, and they always called her when anything is going on, you know. So being there, that gave me the concept, and taking care of her also, I felt this is where I belong to help out.

For several, early life experiences were the basis for their selection of nursing as a career.

**Job opportunity.** The study participants believed the nursing profession offered the opportunity to make a decent living. Agu described how nursing offered him, as an immigrant, opportunity:

> I noticed that people in the medical field were able to get [a] job . . . there were some limitations as to what you can do for a foreigner, and the availability of job in the medical field was more accommodating to a foreigner.

Afam echoed Agu's sentiment. He noted that after graduating college, "there were no job opportunities other than in nursing. So I decided to go back to school and then read nursing." Nnam, on the other hand, said, "Well I decided to become a nurse because it was one of the professions that seem to be with lots of opportunities and flexibility." Chioma noted that job opportunity was the second reason she became a nurse, "the second [reason] is you know, [this] job industry is very lucrative." Several participants named accessibility and opportunity as key reasons for becoming nurses.

**Family and friends' recommendations.** Friends and family members recommended that some of the participants become nurses, citing shorter time in training than becoming a medical doctor. Ikenna's mother, who is a nurse, encouraged him to become a nurse rather than a medical doctor as he had planned. "I wanted to become a doctor . . . but she got me interested in nursing, so from there I just decided to do that." Ozimma shared that her friends encouraged her to become a nurse.

> All my friends are nurses and encouraged me to become one. For me to decide I have to take CNA (certified nursing assistant) class to know a little bit of how it is, to see if it is something that I can deal with . . . so I decided I can do it.

Osita's husband, who was living in the U.S. before she arrived, suggested she become a nurse. As Osita noted, "I mean that it is easier to get a job as a nurse in America and it takes shorter amount of time [to train]. So that was really what influenced me to go into nursing." Nnam also noted, "you know talking to my friends who are in the U.S., they strongly recommended the nursing profession, if I think I can handle it, . . . I felt I can handle it, I decided to go in there."

**Theme summary.** Some participants described the innate drive to work with people who need care, while others told stories about their personal experiences and how this influenced their career choice. A third group described how their economic needs led them to nursing career opportunities, and several drew from the recommendations of family and friends. These factors influenced the participants in making the decision to become nurses. The next theme describes how the nurses developed as professional nurses.

**Developing Professionally**

After deciding to become nurses, the participants sought ways and opportunities to help them begin their journey to fulfill their dreams of becoming nurses. "We have to go to school [and] do all the pre-requisite courses" (Onyeka). Onyeka's statement represents what all the participants had to accomplish to move forward to pursue a nursing career. Eight participants indicated they attended junior and community colleges earning ASN degrees. Nine participants, including six who had previously earned Associate's degrees, went on to receive BSN degrees. Five of these participants attained MSN degrees. Amina and Nnam reported that they were continuing schooling with the goal to complete doctoral degrees.

**Attaining credentials and degrees.** Most participants described high levels of determination in pursuing their nursing education and careers. The nurses who were educated overseas described that in coming to the U.S. they were required to prepare for California state licensure. Adamma said, "Review [for nursing] board training is done here [U.S.], nursing training was done in Nigeria."

Nnam noted, "Well the base training for me was the Associate's degree that is required for you to become a RN at the minimum. So I started as a registered nurse after my Associate degree." Osita described that she attended a city college where she obtained her Associate's

degree in nursing to qualify for the registered nurse licensure examination. She worked for more than 10 years before going back to earn her BSN. Chima described how hard she worked to be successful:

> I knew that for me to be successful that I have to achieve almost till the highest level of education, that's why I kept [going], never stopped, I came from Associate, BSN, MSN, MBA, I didn't take a break while I was going to school.

Before moving to work in acute care settings in the local hospitals, Amara, Chioma, Nkem, Ozimma, and Afam indicated, that they started their nursing careers working in skilled nursing facilities after graduating from various nursing schools. Amina said:

> I got my Bachelor's and my first Master's degree in public health administration. I went through the Master's entry program in nursing, got my certification and ended up with an MSN. . . . I am aspiring to pursue my doctorate degree.

Amina went on to describe her career journey:

> I started as a Certified Nursing Assistant. So by the time I decided to actually go to nursing school I had a good idea of what nursing is about. I worked closely with nurses from the medical-surgical floor to ICU. I floated around to pediatric unit. I had a good experience of . . . different areas of nursing and was able to actually pick my specialty when I started nursing school.

Work entry varied. Chima began her healthcare career as a unit clerk in the hospital. She proceeded to become a CNA with the intention of becoming a registered nurse. She continued to pursue her dream to become a registered nurse and later earned graduate degrees. Onyeka described the process she used to become a nurse:

> I started as a CNA . . . I did CNA to get going. In the process of doing my CNA and taking care of patients, then I was fully confident that this is what I want to do. So I pursued the path.

Ozimma too, also started her career as a CNA. She reported:

> First of all my friends were nurses, and then for me to decide I have to take a CNA class to know a little bit of how it is to see if it is something that I can deal with. That was my reason for doing CNA. . . . So as a CNA, I decided I could do it.

She went on to obtain another license, Licensed Vocational nurse (LVN) before proceeding to earn her Bachelor's degree in nursing. She expressed her intention to continue schooling to earn a Master's degree in nursing in the near future.

**Experiencing U.S. healthcare practice.** The nurses described furthering their professional development through clinical practice and direct patient care skills on the job. The nurses trained overseas had to learn new processes of care. They described that use of technology, unfamiliar hospital equipment, and reconciling the medication names used in the U.S. healthcare environments required them to expand their prior training.

***Technology.*** Eight participants described how the use of technology was a mark of the advancement of healthcare in the U.S. However, four participants noted that technology presented a challenge for them in the process of nursing care. The overseas trained registered nurses described how learning to use technology was a daunting task. Adamma captured this:

> Twenty-five years ago Nigeria was a clinical setting nursing. . . . they were more hands-on in Nigeria. Unfortunately, there was no technology to back those clinical experience . . . we know digital thermometer; there were no mechanical manipulated beds and stuff like that. . . . there was no technology. So coming down here, and finally getting into a high technology industry, it was challenging. . . . coming to a culture where first of all you have to face the culture shock, and then deal with working, facing all the technology was intimidating, and not had any support group or any kind of "nursing for dummies" kind of thing to guide you . . . [to] learn how to handle the intimidating technology that is available. You know the skill in your fingertips, but here you are not dealing with your clinical skill, you are also having to deal with technology skill of it.

Otito similarly expressed how she had to learn to work with electronic equipment:

> The next problem I had was that those electronic equipment I had problem handling them. I didn't know how to use the beds. If I want to lift my patient in bed I had to call someone to show me what to do. So that was basically the major problem I had.

***Pharmacology.*** Some of the participants described difficulty with reconciling the medications used in hospitals in the U.S. They stated that while they did understand the use of

medications and the correct processes for administering them, some of the names and units of measure for prescriptions were different.

> I had a little problem with medication when I came here because the names they use for medications here are quite different from what we use in my country so to do pill pass is so hard. No one is there to show you what you are looking for, so it took me a while to go through, so that was the major clinical problem that I had. (Otito)

Adamma echoed:

> The medications . . . I came to find out that all the medications I was used to in Nigeria are no longer used in the U.S. and that was, I'm like OK Tylenol-Paracetamol, then I have to start reading to realize Tylenol and Paracetamol have same function . . . Pharmacology was very, very challenging.

**Theme summary**. The nurses presented their professional developmental process. The study participants talked about how they became nurses, and described the impacts of their training on their professional development. Some participants earned CNA and LVN certificates that allowed them an introduction to healthcare environments to initiate their nursing careers. Several participants worked in skilled nursing facilities to help them better their skills before moving on to work in other acute and critical care settings. Beyond their formal education and skills acquisition, several participants continued formal learning to keep abreast of changes in the profession and within the healthcare environment.

**Transitions Experienced**

The theme "transitions experienced" emerged as the participants discussed various experiences they encountered in becoming nurses in Northern California. To become a registered nurse in the U.S. was unknown territory for most of the Nigerian nurses, especially those who had their education overseas. While some participants approached these positions with high expectations, others were not sure what to expect. Adamma noted, "To be honest with you I did not know what I was getting into. I had no one who told me OK this is what to expect." Otito described her experience "I could not understand the people and the people could not understand me … I had problems handling them [electronic equipment]. I had to call someone to show me what to do…" Otito continues to describe her professional experience:

> "…I have to learn how to wear pants which I have never worn in my life. In my country we don't' address people by their first names especially someone that is senior to you or even senior in the profession… It is really hard for me to address people especially superiors by their first names" (Otito).

Agu described his experience as a male nurse when he was confronted with the aspect of nursing that involved caring for a mother delivering a baby. "[In] my culture men don't go where women are having babies. So because of that cultural aspect it was very uncomfortable you know, … I was very very uncomfortable in the beginning…"

The experiences the participants encountered in the process to become working registered nurses in the Northern California healthcare environment are captured in the following subthemes: (a) meeting professional requirements, (b) gaining employment, (c) practice reconciliation, (d) recognizing diversity, and (e) Nigerian men in nursing.

**Meeting professional requirements**. To be eligible to practice nursing in a given state, all nurses, regardless of where they trained, are required to pass the National Council Licensure Examination for Registered Nurses (NCLEX-RN®). This examination is managed by the BRN in each of the 52 states. The nurses who trained overseas needed formal preparation for the examination, as their nursing curriculum may not have included some of the courses stipulated by the U.S. boards. The overseas trained nurses described that this was the most difficult task they had to address as they prepared themselves to become nurses in the U.S. Otito said "I took Kaplan class based on recommendation"

Aniete described her experience:

> So when I came here since I was not trained here it was difficult; and most I had to do the NCLEX-RN, and of course, I attended the Kaplan training . . . for like two months before I took my NCLEX-RN exam.

Adamma noted that she too attended the Kaplan Test preparation class to prepare, "Review board training is done here, nursing training was done in Nigeria. I used Kaplan review. Somebody recommended it to me who have taken that in the past gave me recommendation, so I registered."

The nurses who trained in the U.S. met all pre-requisites required to be eligible for training and licensure examination from the local schools of nursing. Ndidi said 'training… I think it's all standard [practice] for everybody in terms of pre-nursing done for either AA, BSN or going further than that. I would say it's the standard for everybody, its the same thing I went through" Agu represented that "I did my pre-requisites-…prior to applying to nursing school" Afam, Amara, Amina, Chioma, Ikenna, and Nnam all echoed similar pre-nursing training experience as Ndidi and Agu. Amina summarized the participants' training experiences and said, " I think we were well prepared." None of the nurses who trained in the U.S. indicated that they used any review preparation for the NCLEX-RN® examination.

**Gaining employment**. Finding employment as RN was described as a difficult experience for the Nigerian nurses who had trained and worked overseas. Aniete noted "Looking for a job after I passed my NCLEX-RN® was a challenge, because everybody [was] requesting from me where is your U.S. experience. I'm like, I just came, I don't really have experience in this country." Adamma similarly noted:

> But nobody will hire you because you didn't have no clinical experience in U.S., and no training experience in U.S. It wasn't an easy thing. You had to base whatever, by if your just begging God to let one person to give you one opportunity so that you can go in and see what is happening, and from there, unfortunately, you fell out of new grad orientation so nobody will hire you as a new grad, because you are not a new grad. So the opportunities weren't there.

Agu said emphatically, "you don't have a chance!" and then went on to note:

> There are other subtle things . . . looking for a job for instance. You look different or you speak differently, your name sounds differently, is very difficult sometimes, you know, for you to be even called for interview. And the interview process. First of all somebody has to give you that interviewing opportunity for you to prove "I can do this". . . . I can tell you, that first of all getting that interview process was one of the biggest challenges, because you did not have a chance at all as a foreign trained nurse. Your chance of getting a job is as zero. . . . Of course your resume doesn't include job in U.S., so you don't have any chance. Somebody who is reading your application finds out that this person has no job experience in the U.S. and that application goes to the bush or shredded.

The experiences of overseas trained Nigerian nurses reflected an initial inability to secure employment. Many appeared to enter nursing in the U.S. in CNA roles.

***Nursing practice in the U.S. and other locations.*** All participants described looking forward to nursing in a highly functional healthcare environment. Two participants reported on their perceptions and opinions of nursing practice prior to becoming nurses in Northern California. Chioma said, "Prior to my entering into nursing school, I was scared because I already . . . heard from people that it is really hard . . . But in practice it wasn't that hard." Osita on the other hand came to believe that "Nurses actually do all the work, . . . doing total care. So it was harder than I thought in acute care setting."

Those educated and trained abroad evidenced amazement that in reality the U.S. healthcare industry lacked both perfection and completeness.

> I thought they have all the answers. When I say they, I mean the medical field, those nurses that, you know, they have it all mapped out . . . I can say that is somewhat not realistic, but I still wish that we consider we can live up to that ideal but it is really not realistic[ly] given . . . the things we have to consider, we take into consideration when delivering care that's what makes it a non realistic expectation. For instance, socio-economic background really affects the care. What you can provide, how care you provide is received by that person, and sometimes, depending may not even have the resources they need to take care of themselves. (Ndidi)

Aniete similarly expressed, "Well my expectation [for] anybody coming from outside to the United States, always has high expectation that everything to be perfect." Ikenna said:

> Well I guess I thought it was more perfect than I expected . . . from being a little kid and going to the pediatrician . . . I felt like everything was more focused on your well being, as opposed to insurance company, money and thing[s] of that nature… so it is actually money versus caring for the human being, and so I guess I'm actually living it. . . . I am seeing that . . . it is not always . . . the patient first, its more about how is this patient going to be paid for. I am seeing that, you know it is not this you know patient is sick just take care of them regardless. It's always the money that comes first at least in America and I guess that's part of the culture of capitalism, you know.

**Recognizing diversity.** As noted in chapter two, the U.S. population is made up of people from diverse cultures. Similarly, the workforce in the hospital environment in northern California, comprise individuals from diverse cultural backgrounds. Several participants described the healthcare environment in Northern California as being very diverse. Ozimma described the range of diversity, "So we have Spanish speaking people, we have, of course, African American, . . . people from Africa and we have Whites. We have Asians-Tibetans Filipinos, and Indians." Amina noted:

> We have a diverse cultural base, you meet people from all cultures and religions and have different practices and belief system and you have to adapt. You have to . . . we are saying you are needing to learn things about people . . . to be able to effectively do your job you have to know they have practices that are different than yours and try to find a common ground when dealing with them, it's quite an education.

Afam's comments further reflected the complexity and possible care implications for the diverse patient population.

> They come from different background, cultural background and . . . we are trained to respect their background and work with them, but the people, some people don't want certain things and we have to respect that . . . the facility has policy for so many things. If somebody from . . . Jehovah Witness . . .say I don't want my child to get blood and the child is under age, is not going to fly because if he needs blood two doctors can sign and override that, that is standard (Afam).

Nnam shared, "As far as I can tell, [this] is an environment that enabled me to practice to the fullest extent." Chioma echoed the appreciation of working in an environment with people from diverse backgrounds as both nurses and patients, "I love it because it gives me the

opportunity to see different side of the world like low income, the homeless, like people who are different from you. It really gives me the opportunity to appreciate life more." Osita described the impact that working in a diverse environment, "[it] has really made me tougher and I believe we are stronger too." Ndidi framed the effect of diversity noting, "I would say it made me . . . someone who does not just stop over an obstacle. We find ways to make it work." Adamma spoke with passion about her experience of diversity and how she used it to support her patients.

> I couldn't have been in any other place. I felt this is the kind of environment I really really love and I am so glad that I am working in that environment because it put me in an environment to care for people who have no advocate; who have a lot of barriers, like me when I came here: newly-language, socio-economic, financial - and it puts me to find myself in their position and it brought out the best of me in my nursing carrier. So it is the best environment I could be in (Adamma).

The U.S. healthcare environment seems to provide diverse groups of people working together the opportunity to experience and learn about various cultural behaviors.

***Culture.*** Study participants verbalized an awareness of the differences between their home culture and the current diverse culture in which they work. Otito described an experience she had that was common among the participants:

> This place is quite different from my cultural background . . . first of all I have to learn how to wear pants, which I have never worn in my life. You need to learn how to address people. In my country we don't address people by their first names, especially someone that is senior to you, or even senior in the profession, you don't address them by their first name. Like a common thing it is really hard for me to address people especially superiors by their first names (Otito).

Onyeka pointed out:

> Ok culture-wise is different because we came from different culture. The way they perceive certain things is different from the way we learned, or what we were brought up with so we have to see that, and sometimes we have to respect their own culture you know . . . maybe the eye contact, the touching . . .we are used to hugging. We are used to

> not looking directly in the face when you are talking to somebody, but the Americans take it as disrespect, so is those things you have to build yourself that when you talk to a manager or co-worker they want you to look straight in the eye and talk to them. So we are not brought up that way. So it is something that we learn to adapt. To us, looking at somebody when you are talking to him or her is disrespect, but for Americans they look at it differently.

Osita described a dilemma she experienced:

> You know back home we are raised not to make eye contact you know like its not respectful especially with an elder, somebody in authority. So, but I have learned that actually the reverse is the case here. If you are not making eye contact it means you are not respectful.

Through their voices, the participants described how differences in culture required them to put in the effort to understand the common ground that allows them to effectively practice nursing.

***Communication.*** These participants from Nigeria lived and were schooled in an English-speaking country. They described that they can read, understand, and write English without a problem. Nnam suggested, "Communication is communication and you can communicate in any language you know." Many participants reported that how others responded to their speech pattern and accent was the most challenging experience they encountered. Participants described situations in which co-workers and patients appeared not to be able to understand them. Further, some participants described that initially they did not understand colleagues and patients speaking with a range of American and foreign accents. Agu said:

> I came from a different environment with different language and accent that sometimes . . . some pretend that they don't understand what you are saying . . . even though you are speaking good English with a different accent from their own . . . people make you feel you are not a human being (Agu).

Ozimma noted, "It's just the accent that sometimes you have to repeat once, twice before some of them can understand what you are saying." Onyeka said, "Sometimes we deal with

patients who may not understand what you are saying or the way we speak or maybe the pronunciation." Otito reported, "My accent was a big barrier at first it was hard for me to understand people just as it was hard for them to understand me." Culture and communication were two elements of diversity that affected the transitions of these Nigerian nurses into U.S. healthcare organizations.

**Men in nursing.** Four participants in this study were male nurses. As noted earlier, several factors led to the participants' choice of the nursing profession. Caring for people in need, the recommendations of family and friends, and the need to have job opportunities open to them were the general reasons the participants chose to become nurses. The Nigerian male nurses who participated in this study described some experiences they encountered during training and in practice that they believed reflected gender bias.

The men shared that in training, sometimes the professors made reference to students in their classes as "ladies" even when there was a male student among them. The participants also reported that a lack of professional resources for men created hardship. Finding work apparel for men was identified as a very challenging experience.

> Then sometimes you go to buy stuff and find out that you know they have a lot of stuff for the ladies only. Its like they don't expect the guys to be there so you work harder to find stuff to buy as a guy (Nnam).

Care for female patients was also identified as one of the Nigerian men's difficult experiences. In some instances, the cultural upbringing of the male nurses created challenging situations.

> Being a Nigerian male too and you know that we have our expectation like this is what men do and this is what women do but you are at work you have to set that aside and do what you are employed to do. (Afam)

Agu spoke about how he seeks permission from both the patient and her family before approaching to care for a woman as she delivers her baby. Although one patient and her family had no problem with Agu taking care of her, he stated, "But still it was very uncomfortable." Nnam also observed that some of the challenges were the result of his gender:

> I approach everything that happens by trying to find out why it is happening and the main reason the things are happening you know. I address my challenges that come based on what is going on. I don't always see it as happening because of who I am. Some do happen because of who you are as a gender, so for me if I end doing doctorate I might be looking at the challenges faced by male Nigerian nurses . . . we face all kinds of challenges. . . . I am surprised . . . when you are going through school, you are the only person who is a guy, who is black. Oftentimes, people mistake me as the doctor and say, "hey Doctor," I say, "no, I am a nurse."

Communication style seemed to be one of the challenging areas for the male nurses. Ikenna described how his colleagues perceived him as aggressive.

> I guess I have this hard outer shell, so if someone says something in a certain way or does something in a certain way I have to be careful how I respond to them because sometimes they take it as I'm being harsh. Sometimes people misconstrue the way I'm talking as being aggressive, or . . . being mean. I don't necessarily feel like I'm being harsh . . . my intention is always to have the best outcome for the patient.

Agu, on the other hand, reported that his challenge was when "Some people prefer to say that they don't understand what you are saying, . . . it is a little challenging, even though you are speaking English with different accent from their own."

Nigerian male nurses encountered gender-based issues in their professional practice. They described challenging issues around communication, perceived aggression, lack of readily available male professional apparel, and cultural inhibition in caring for female patients.

**Theme summary.** This theme described the experiences of the study participants in their process of becoming registered nurses in the U.S. Their transitions reflected experiences they had in both training and accessing employment in the U.S. These experiences are captured in

their narratives about finding employment, meeting professional requirements, working in a diverse cultural environment and acknowledging gender differences.

**Responding to Challenges**

This theme describes the experiences of the participants in the various healthcare environments in which they worked. Participants spoke about the hurdles they faced in form of microaggressions, intercultural and intracultural conflict, and unconscious bias. They also described their coping styles, and what they believed about becoming successful nurses in Northern California healthcare.

**Facing hurdles.** Study participants described several hurdles they experienced in their professional practice. Discussed below are the examples of the hurdle the participants experienced. The hurdles were not physical in nature; rather, participants described experiencing a sense of loneliness, lack of support, and dismissive behavior perpetrated by colleagues and patients while at work. One participant described her experience with a preceptor as a new nurse, "The interesting thing is that everything was fine . . . until my recommendation . . . when it is time to make recommendation, they threw me under the bus" (Nkem). Another participant described her experience and said "Your patients don't think you are qualified enough to take care of them. Your fellow nurses . . . nobody feels like you are qualified. . . . even the janitor, housekeeper, everybody think they know better than you" (Adamma). The participants reported cross-cultural and intra-cultural conflicts as a result of misunderstanding and misinterpretation of cultural differences. They also described issues they faced as a result of what was perceived as unconscious bias, favoritism, and limited professional support from coworkers.

***Microaggressions.*** Many of the study participants reported that others reacted to their accent, and frequently this resulted in their experience of dismissive behaviors from both patients

and staff. They described that they experienced this when they first introduced themselves as the registered nurse assigned to care for the patients. Ndidi, who trained as a nurse in the U.S., said:

> There have been occasions where some patients say, maybe they don't understand me or sometimes some patients when they hear you talk and say, "you are the nurse?" They say, "my medication nurse?" Not the one to help me [with activities of daily living].

Otito, who trained in Nigeria described a similar experience, "Sometimes some of my patients because of the accent they won't want me. They say, like 'go get a nurse'. It's hard for them to believe that I am the nurse because I have accent."

Agu candidly said, "Other people make you feel you are not a human being." Afam described his experience with co-workers:

> Speaking of co-workers, the patient, yes . . . the accent type of thing, some complain, I mean . . . we are all human beings, whether they understand or not, you don't know, but some people when once they hear your accent then they would say you . . . because of your name or the way you . . . they say . . . 'can I get somebody that speaks English', and you are speaking English . . . . when some co-workers get mad they say 'we can't understand what you are saying' or they want to put you down somehow.

Nkem also noted, "I think . . . the fact that you are an African they immediately like close their minds to understand you. The fact that you have an accent, I don't know they just hold on to that." Chioma summarized it well:

> The accent is a big thing in communication you know. Sometimes you face the frustration of not being listened to. Most times they are shut off just hearing you speak. Due to your accent they are already shut off, they don't want to listen. So what ever you say henceforth is not taken you know, so, but what can you do? You need your job and you have to survive, so all you do most times is you repeat, I repeat myself more than . . . I supposed to . . . in order to get my message across you know. That is very frustrating.

***Intercultural and intracultural conflict.*** Participants described conflicts with people of other cultural backgrounds. Ozimma described her staff as being from diverse cultural backgrounds including African, Asian, Latino, African-American, and White. She described her

leadership experiences as a nurse manager in working to resolve a complaint presented to her by two people of different cultural backgrounds and her need to reconcile perceived offensive behaviors.

> Well even between the coworkers . . . we have diversity. . . . sometimes it's a cultural thing, is way too much where . . . we say something they find it offensive and then for them they say something and then we find it offensive. . . . and then the Spanish girl went and reported that she disrespected her. So, it was a big case, because she said she 'will file a complaint that she disrespected her and pushed her actually'; when the other girl, the Nigerian nurse was trying to explain that she was only joking just by touching her and she said she hit her. . . . The cultural challenge in my job is mainly with co-workers, not even with the patient and family, it's more of the co-workers because we are very diverse on my job.

The participants reported that sometimes the conflicts were between the Nigerian nurses themselves. Aniete who is also in a leadership position as a nurse manager working with other Nigerian nurses described her experience:

> I had to have a staff meeting . . . involving Nigerian nursing assistants and registered nurses. We have nursing assistants saying [to registered nurse] "you can't tell me what to do." [Registered nurse to nursing assistant] "You can't say that to an American charge nurse or manager." [Aniete to nursing assistant] "Because you are both from Nigeria she can't tell you what to do because you are older than her," so there is no professionalism.

Conflict both cross-cultural and within culture are hurdles faced by these nurses.

***Unconscious bias.*** The participants described experiencing differential treatment in some administrative decisions. They described bias they perceived experiencing in daily assignments, the granting of holiday and vacation requests, and resolving conflicts among staff. Osita described in specific terms her response to these experiences.

> There is still a little bit of racism going on you know. When you come in you may get the worst assignments because you are not from the same ethnic group as the person that made the assignment. . . . when they make assignments they give the easiest ones to their people, and give you the worst. I mean it is still happening even [un]til today, where you know you are from Africa they give you the worst assignment. You always have to fight for your right.

Chioma described her experience in even more powerful terms:

> Some of the problems I faced . . . so many times. Sometimes my badge will be showing . . . what job I do as a registered nurse. So when I want to take care of [a] certain patient they tell me . . . can you . . . so and so person take care of me instead of you? Can your boss, the person they are calling my boss is the CNA [Certified Nursing Assistant] or my MA [Medical Assistant] so they will tell me can I talk to so and so person instead? So I say sure. . . . then when they get to that person, they find out . . . I am the RN in charge.
>
> I have faced a situation whereby they delivered narcotic and its only the RN that is supposed to sign off and I was standing there, the person that was delivering the prescription ignored me and went to my MA [and said] please can you sign this off, she referred back to me, . . . she is the RN on duty, you have to talk to her. She came back to me. . . . So such things you face on a daily basis you know. Well I mean you still have to deal with it, you just go with the flow as if nothing has happened you know. You have to do your duty and you have to do your job.

Amara talked about her interactions with patients:

> I am not gonna say it's the race thing but we should not underrate that. So some residents don't want you based on your color. . . . So all you have to . . . to maintain your professionalism is all you can do.

Afam, Nkem, and Onyeka described their experiences with dismissiveness and being denied job opportunities based on their experiences with bias.

> If you think of what goes on everyday you will have problem. A woman called me for an interview [for RN position] . . . I went to her office. She saw me [without any professional formality of greetings] and said, "Oh I don't have any position for "an." And I was thrown off. I did not know what to say. I did not apply for CNA and she had my application, I told her . . . "I applied for RN position and you called me for an interview." She said, "Oh that position, I don't know what I did, I filled it up." It's a lot of challenges when you come to that, that stuff. (Afam)

Afam described another situation when he arrived at work and was instructed not to enter a particular patient's room due to a prior incident that had taken place. The patient became agitated when she was to be picked up and transported to the x-ray department for a scheduled test. The transporter who was a Black person pressed the emergency light as he observed the patient was very agitated, she had pulled out her intravenous infusion and was about to fall out of

bed. When the other staff members responded to the emergency call, the patient said to them, "Take him out, take him out. I don't want to see him. I am allergic to Black people."

Onyeka described how the rules seemed to change when she applied for the charge nurse position:

> I had an experience one time. . . . I was doing more relief charge nurse all the time. . . . based on charge nurse is by seniority, I applied to that position I was supposed to be the most senior to get it. So because they had another White guy that came in you can see, . . . the manager, there is favoritism and all those things, which was not right and they knew it was not right. Basically I was supposed to get that position now they changed the whole thing. Certain positions you know you are qualified for, they rather give it to their own people you know.

Nkem described her orientation experience when her preceptor, who had a different cultural background, gave her an unfavorable recommendation without explanation.

> If you are doing something, somebody is training you and you are not doing something right she is supposed to tell you, you are not doing it right. . . . but I never had that experience. But when it comes to make recommendation, "they throw me under the bus." So I don't know. . . . I was not happy when that happened. It does not matter what somebody does, you will still move forward you know and they just hold you back a little.

The Nigerian registered nurses powerfully described their experiences. They explained that their experiences led them to take extra care to prevent any action that might warrant any administrative intervention. They took extra care to be perfect in their daily practice. Consistent across the participants was that they appeared to cope with these experiences by becoming hyper-vigilant in their nursing practice.

**Coping styles.** The participants described ways they managed challenging situations. Different coping styles were described. Onyeka said:

> So it depends if you wanna' fight for it or you just wanna' move on and just do what you are doing. So I am always the kind that moves on, I don't fight. I'm not the kind that fight, some people say go fight it, call union.

Amara similarly noted:

> Approach is the thing that will guide you. You don't react to the way people react. So you try to find a way to treat people and find the right way to interact with people. . . . So you are trying to avoid any conflict.

Osita described a more direct method of approaching issues:

> So when things like that happens, I go to the . . . whoever that is responsible, like the hard assignments. But I will go with a smile. I won't go with aggression you know, just to say, "hey you know this is not right, what do you think?" And they usually listen you know. I try to approach them in a positive way.

Ikenna reported that he coped by involving himself in extracurricular activities and family interactions. He described doing "a lot of reading, lot of discussing with my mom or my significant other. . . . I guess those are my coping mechanism, . . . even exercise, hanging out with the cousins."

Adamma's statement offered a view shared by several of the participants:

> I would tell you that there is no menu or textbook to tell you how to deal with difficulties. Well there is a lot of books that will tell you how to deal with difficult environment but in my own case which I, and when you talk to all the Nigerian nurses that came to this country all have similar stories. There is no textbook out there that tells you this is how to handle it. It comes with your experience.

The participants described a range of approaches including avoidance, hyper-vigilance, communication, family support, flexibility, self-talk, reading, exercise, and situation assessment.

**Success factors.** The participants indicated that their nursing practice was successful for varied reasons. Participants described the importance of professional behaviors leading to positive patient outcome and job satisfaction. Osita described success as a measure of her daily performance.

> I feel successful when at the end of my shift my patient says, "I want to thank you so much for taking good care of me." I really appreciate it you know. I mean it makes me fulfilled and I know I've made that difference.

Adamma described characteristics that supported her success:

> What allowed me to be successful, I tell you again is being humble, then positive and being able to take it one day at a time, and being able to know that . . . if this becomes my mantra-if I don't want this to happen to me then I wouldn't want it to happen to my patient. So I started treated each and every patient I come across personally . . . so treating every patient like me was another thing that made me a successful clinical nurse.

Similarly, Onyeka described:

> What allowed me to be successful I think because I don't try to get into trouble with everything. You just keep going. If I can further my education, I focus on my education. . . . And again I am a very hardworking person. . . . We are not here to play games. . . . you strive to be the best.

Chioma described her success based on her spiritual dependence on God. She said:

> Number one is as a Christian I don't leave my house without praying. I just get up in the morning, I do my prayers I commit myself, my job, everything I am doing today and my family to God's hands and I leave.

Afam who worked for 20 years as a registered nurse in the U.S. described her success as a matter of longevity and maintaining her license:

> If you are able to do this job on a daily basis for so many years as I did and retire yourself, . . . without getting into trouble, one thing or the other they take your license or suspend your license or for any reason like that or get terminated you know.

Amina, Nkem, Amara, Chima, Ikenna, Ozimma, and Nnam described success factors as including focus, hard work, and family support. When asked what supported their success they said, "Work hard and not take things for granted" (Ikenna). "Determination" (Ozimma). "Put patients and families first" (Chima). "Focus and work hard with family support" (Nnam).

**Theme summary.** This theme presented the challenges the nurses faced and how they took action for success. The hurdles, while serious were not perceived as reasons they should not pursue their interests in nursing profession. All the participants described their success in

nursing practice. The description of successful practice reflected their passion, their willingness to do hard work, family support, and positive patient outcomes.

## Results and Interpretations

Findings from this study illuminate the perceptions and lived experiences of Nigerian registered nurses working in healthcare in Northern California. The study's findings describe the essence of the events that shaped the 16 participants' lived experiences with nursing in Northern California. Their experiences shed light on practice realities experienced. Four results emerge from the findings, and Figure 4 offers a graphic representation of the study's results.

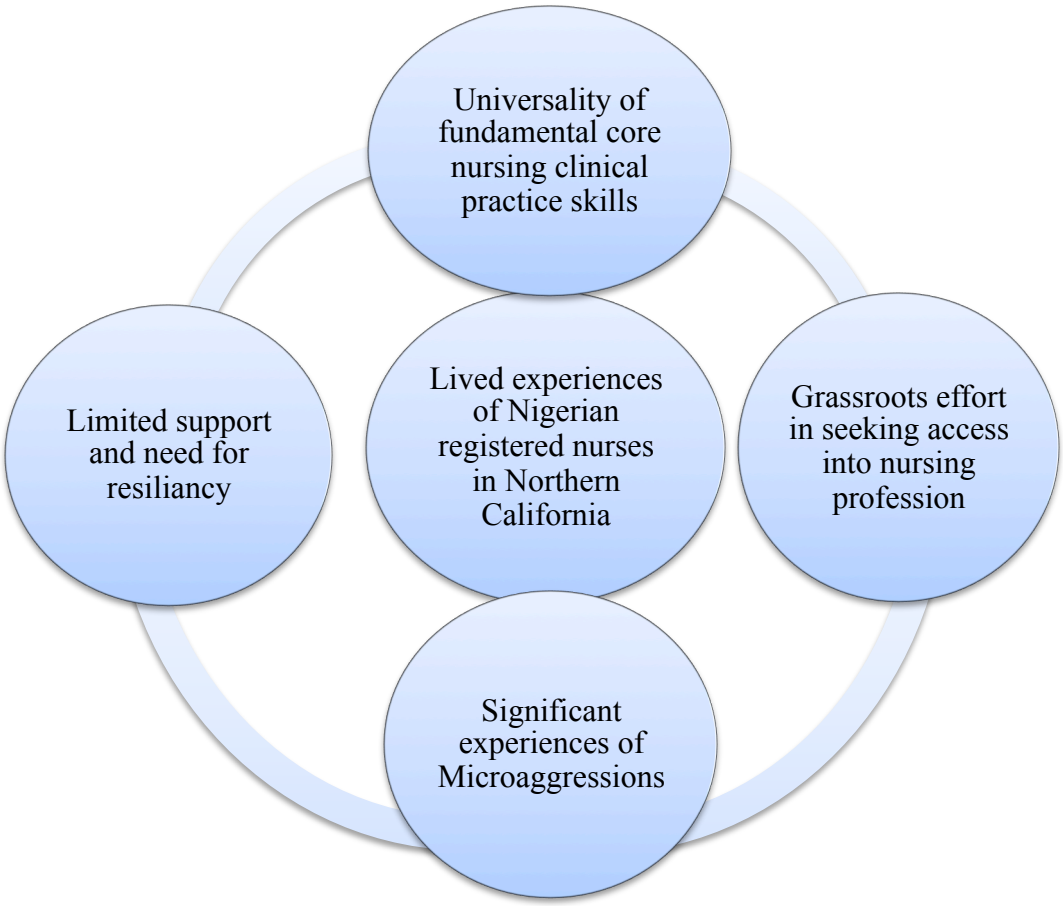


*Figure 4.* Emergent results from the findings.

These results are interpreted through the literature reviewed in Chapter 2 and form the basis for the conclusions and recommendation suggested in Chapter 5.

**Result One: Universality of Fundamental Core Clinical Nursing Practice Skills**

Although participants described differences in the tools used and processes followed in providing healthcare, they did not report having difficulty delivering basic core clinical practice competencies. The participants' observations in this regard seem to be congruent with the findings in the literatures. "There is a wide discrepancy around the world with regards to standards for nursing education qualification, and scope of nursing practice (Wolcott et al., 2013, p.263).

Much of the debate in the literature seems to be about defining standards of practice and developing universal nursing competencies for safe and competent care, rather than about core nursing skills. As was noted in the literature in chapter 2, many researchers tend to think that there seems to be an unclear definition of what clinical competency measures entail, (Allen et al., 2008; Axley, 2008; Cronenwett et al., 2007; Edwards & Davis, 2006; Redman, Lenburg, & Hinton Walker, 1999; Wolcott, Llamado, & Mace, 2013; Yanhua & Watson, 2011).

The understanding of basic nursing care of patients whether the nurse was trained overseas or in the U.S. was apparent. The participants, especially those who trained overseas, proclaimed with pride their reliance on the nursing skills they learned prior to coming to the U.S. One participant seemed to capture the thoughts of these participants in the expressed satisfaction that they were prepared to function well in other places like the U.S. through the nursing training they received in Nigeria. Otito said, I believe nursing is the same everywhere. Once you are a nurse, you can practice anywhere you find yourself." (Otito). Adamma echoed similar thoughts and reflects:

> … I can tell you one of the best skills I got in Nigeria was practical skill in nursing. … I had a very good IV skill, which I attribute to my practice or my training in Nigeria, because over there you don't have the guided lamp and all the tools… I feel I could start IV on anything or anybody so that skill was good. My person-to-person skill was good because you don't have the machines and monitors reading it out for you. You have to touch to feel the heart . … so all those skills came really handy as I applied those skills… I am so glad I did nursing in Nigeria because it made me a better nurse when you put everything together. No regrets at this point (Adamma).

The universality of the core clinical nursing skills is similarly described in the research of Lin (2014), Wheeler et al. (2013), and Yi and Jezewski (2000). These studies also concluded that nurses from around the world who participated in various studies were well prepared to practice in the U.S. Wheeler et al. (2013) noted that other internationally trained nurses from Asian and African countries thought that nursing skills were functionally the same regardless practice area. Nurses from the Philippines noted that variations in practice areas are around scope of practice, technology and legal implications, (Lin 2014).

**Result Two: Grassroots Effort in Seeking Access into the Nursing Profession**

All the participants completed their nursing training and passed the required licensure by the state of California examinations, as evident in their titles as registered nurses. However, there seems to be two categories of grassroots effort by the nurses trained overseas and those trained in the U.S. As noted by both Adamma and Otito, for the nurses who trained in Nigeria the effort is put into the preparations needed to sit for the NCLEX-RN licensure examination. This seems to be the general requirement for all the internationally trained nurses. As noted by Bola et al., (2003), Engebretson et al., (2008) and Maier-Lorentz, (2008) the training for the overseas trained Nurses address the issues in the U.S. mainstream culture, which is thought the nurses who trained in the U.S.

Many of the participants who trained in the U.S. described that they started their nursing careers as CNAs and later became registered nurses. The participants used this avenue to test their level of passion for the profession before embarking on it. "… I did CNA first because I know it's somewhat easier to get a job in that field as an immigrant." Ndidi. Similarly, another participant noted:

> … my friends were nurses and then for me to decide I have to take a CNA class to know a little bit of how it is to see if its something that I can deal with… So as a CNA I decided I can do it… its very amazing and I just wanted to be part of it. (Ozimma).

Onyeka also said "I started as a CNA … to get going. In the process… I was fully confident that this is what I want to do. So I pursued the path." Onyeka.

The participants earned multiple nursing and non-nursing degrees. Eight participants (50%) had earned ASN degrees, and seven (44%) earned BSN degrees. Before entering the nursing profession, five participants (~31%) earned Bachelor's degrees in other areas of study. Six participants (38%) had earned a MSN degree. A few of those who earned Master's degrees noted they were looking forward to pursuing their doctoral degrees in nursing. This is similar to Wheeler et al.'s (2013) research in which two thirds (66%) of the study participants started their nursing career by earning ASN degrees, then went on to earn BSN and MSN degrees.

**Result Three: Significant Experiences of Microaggressions**

**The experiences of microinvalidation.** The experience of microaggressions emerged as common occurrences the Nigerian nurses encountered. Microaggressions, as noted in Chapter 2, is an umbrella term describing various experiences nurses from other cultures encounter while living and working in the U.S. Microaggressions have been described by Sue et al. (2007) as both intentional or unintentional verbal, environmental, or behavioral activities, which impact the targeted individual or group deeply in their everyday lives.

The microaggression phenomenon is said to be currently difficult to categorize, as its occurrence remains subtle and in various forms. However, the experts have identified microassault, microinsult, and microinvalidation as the three types of microaggression, (Bleich, 2015; Sue et al., 2007). Sue et al. suggested that microassault and microinsult are obvious behaviors that can be challenged or are reportable. The perpetrators seem to know to avoid such or face the many sanctions that are put in place. The study participants seemed to have experienced more of the third type of microaggressions—microinvalidation. This is characterized by subtle behaviors that "exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color" (Sue et al., 2007, p. 274). Sue et al. further noted:

> There is an urgent need to bring greater awareness and understanding of how microaggressions operate, their numerous manifestations in society, the type of impact they have on people of color, the dynamic interaction between perpetrator and target, and the educational strategies needed to eliminate them. (p. 274)

Due to the subtle nature of microaggressions and the obvious effects experienced by the victims, participants called attention to the components of this phenomenon.

**Mistaken professional identity reflected bias and stereotyping.** All the participants described encounters that reflected how others experienced them. The participants frequently described being identified as CNAs or the "other nurse" rather than degreed registered nurses assigned to care for the patient. This occurred not only with patients, but also with colleagues from other units or departments who interacted with the nurses during patient care.

The participants further described that they were discounted and ignored by patients requesting another nurse or were not recognized as the nurse in charge of the unit. The participants lamented missed opportunities for camaraderie with colleagues. This result was

similarly described by Xu et al. (2008) in their research on nurses from the Chinese culture who reported such experiences. They concluded that the nurses experienced isolation due to their inability to participate in simple conversations to build professional relationships. Xu et al. did not find that the Chinese nurses were perceived by others to be in lower professional positions, as was the case with the Nigerian nurses.

**Accent associated with a lack of skills.** The participants described how their spoken speech, specifically their accent, affected how others experienced them. Neither the location of their education nor how long the participants lived in the U.S. affected this reaction. The participants described how their speaking with an accent seemed to be associated with or simply interpreted as a symbol of their lack of skill. This finding is similar to the experiences of Chinese registered nurses working in the healthcare system in the U.S as reported by Xu et al. (2008), who indicated that the nurses reported perceived discrimination related to communication challenges. The participants further described having to frequently repeat themselves to the patient or staff in question. They also reported that sometimes they had to speak slowly or write out their message to assure the others understood. This experience aligns to the experiences of nurses from other cultures working in the U.S. healthcare industry as described in the research of Boykins (2014), Kawi and Xu (2009), and Lum et al. (2015).

The participants also described their own challenges in being able to understand some of the patients and colleagues, from other parts of the U.S. and especially those from other cultures. This created a stumbling block, but was not described as a hindrance to the performance nursing care of their patients. Ea (2008) and Hart and Moreno (2013) described that nurses are able to adapt to different culture after they are successful in overcoming the initial conflict. The nurses'

experiences are similar to those of the Chinese nurses in a study by Xu et al. (2008) where the nurses felt discriminated against due to their inability to instantly adapt to the U.S. culture.

**Hyper-vigilance and the burden to be perfect.** The Nigerian nurses reported experiences in their professional lives that impacted the value of their daily work, academic preparation, and professional training. Several of the participants also reported favoritism toward a particular group of people (frequently the majority culture on the unit). As a result, the participants described carrying out their daily nursing functions with the burden of fighting for equitable and safe patient assignment, as well as taking extra care to complete their assignments impeccably. This experience aligns with Xu et al.'s (2008) description of similar encounters described by Chinese nurses who reported that fellow nurses, patients, and their supervisors treated them differentially. Parrone et al. (2008) also described the hyper-vigilant behavior evidenced by nurses from different cultures. Lack of action by leadership in response to these situations further cemented the effect on the victims and aligned with Mapedzahama et al.'s (2012) findings. These experiences are reflected in ongoing research as a form of aversive racism known as microaggressions.

**Result Four: Limited Support and the Need for Resiliency**

The participants described being the only registered nurses from Nigeria working on their units. They reported that this frequently led to a sense of isolation and expressed feeling unsupported. Aniete who did not have any familiarity with the U.S. healthcare environment during her nursing training captured this experience:

> …getting into the door I did not get any preceptors, they just show you for …six weeks orientation [which is usual for U.S. trained nurses] and just get in there and do the job. So either you know how to do the job or you don't know how to do it. …it was difficult and no one prepares you that this is what you gonna go through you know. (Aniete).

The participants did not seem perturbed by these experiences. Osita said:

> … it has really made me tougher and I believe we are stronger too you know because I mean when I first started I didn't know I will be able to do it but as the day goes by it makes me tougher and stronger…" (Osita).

The participants reported putting efforts into training and learning the skills and the rules of engagement. They held the nursing profession dear enough to find ways to cope with their negative experiences. They described remaining hopeful that lifelong learning will help them to continue to be in the profession they have chosen. The participants' perceptions and opinions seem to align with Kawi and Xu's (2009) findings that education, support, self-determination and expressions, and professional work environment are the factors that helped nurses from other cultures to function well in the hospital environment.

Ea (2008) similarly found that participants from other cultures use training and education to adapt to new work environments and cope with challenges of difference. The Chinese, Filipina, and Korean participants in other studies also used education and training as tools to overcome the barriers they experienced their nursing practice (Lin, 2014; Xu et al., 2008; Yi & Jezewski, 2000).

## Summary

The findings and results from this phenomenological study provide insight into the experiences of Nigerian registered nurses working in the healthcare environment in Northern California. The perceptions and viewpoints expressed by the participants offer an understanding of the commonality of their experiences that aligns with and adds to those presented previously. The findings and derived interpretations and results from the study provide information that informs the conclusions and recommendations offered in Chapter 5.

# Chapter 5: Conclusions and Recommendations

## Introduction

The purpose of this phenomenological study was to explore the lived experiences of Nigerian registered nurses working in the U.S. healthcare environment in Northern California seeking to understand the cultural, social, and educational challenges they face. Understanding the lived experiences of Nigerian registered nurses working in the Northern California healthcare system may enable nurses and regional healthcare organizations to identify resources to better support their acculturation.

The following questions guided this research study:

1. How do the Nigerian registered nurses describe their challenges working in the U.S. healthcare environment in Northern California?
2. How do the Nigerian registered nurses describe the effect of challenges on their personal and professional lives?
3. What are the perceived attributes for success identified by the Nigerian registered nurses working in the U.S. healthcare environment in Northern California?

The sample in this study consisted of self-identified Nigerian registered nurses working in the U.S. healthcare environment in Northern California and included 12 female and four male RNs who were either trained in a school of nursing in the U.S, trained overseas, or trained both in the U.S. and overseas. All participants passed the NCLEX-RN® and had worked for at least one year in the U.S. healthcare industry in Northern California.

Analysis of the interview data yielded four themes about the lived experiences of Nigerian registered nurses working in Northern California: (a) influences to become a registered

nurse, (b) developing professionally, (c) transitions experienced, and (d) responding to challenges. Further theme and subtheme analysis led to identification of four results and interpretations that offered more insight to the shared experiences of the nurses. The four results are: (a) universality of fundamental core nursing clinical practice skills, (b) grassroots effort in seeking access into the nursing profession, (c) significant experiences of microaggressions, and (d) limited support and need for resiliency. Conclusions and recommendations are informed by the study findings.

## Conclusions

The findings of this study provide evidence of the experiences of Nigerian registered nurses working in the United States healthcare industry in northern California. A trail of evidence provided through the data described in Chapter 4 provides the context to answer the research questions that guided this study.

### Research Question One: How do the Nigerian registered nurses describe their challenges working in the U.S. healthcare environment in Northern California?

The Nigerian registered nurses working in the healthcare industry in Northern California identified five areas of transitions they had experienced to become practicing nurses. These included: (a) meeting professional requirements, (b) gaining employment, (c) professional practice reconciliation, (d) recognizing diversity, and (e) men working as nurses. The Nigerian registered nurses undertaking the journey to practice nursing in the U.S. described major changes in their lives. Bridges (2004), in his book *Transitions: Making Sense of Life's Changes,* described that there are three stages of transition: (a) Change initially involves ending previous undertakings, which frequently creates feelings of shock and fear; (b) The *ending* stage is followed by the individual reaching a seemingly *neutral* stage, a period filled with confusion and

uncertainty about what to do next; and (c) Then a new *beginning* starts when the individual gains clarity and devises a new goal and works toward it. The study participants described their experiences with major life and career transitions and all the related trials. For all the participants, the act of leaving their previous experiences and familiar home environment for a new and unfamiliar environment created an ending. For some, it led to a change in career path; others experienced changes in family dynamics. They all encountered change in professional and societal cultures.

The experience of an unfamiliar career and work environment left the participants in the neutral zone where they were left to question if they had made the right decision to pursue a career in nursing in the U.S. However, the inner motivation to provide care for people and the external support from families and friends allowed them to adapt to new career and or work environments.

To meet the professional requirements to become nurses, many of the participants engaged in educational training and skills development through attending a range of nursing programs and working as CNAs. All the participants studied and passed state licensure examinations. Many of the nurses who trained overseas were unfamiliar with the California system and participated in review studies, such as those provided by Kaplan, to aid them in their studies to take the licensure examination.

Gaining employment was challenging, especially for the nurses trained overseas who had no hospital reference point in the U.S. for experience in patient care. They described not knowing how to navigate the employment maze in the healthcare industry in Northern California. Some of the nurses who trained overseas relied on friends to guide them as to how to start their nursing career after passing their examination and becoming registered nurses. It may

have been this lack of knowledge that led some to start their career as CNAs while holding nursing licensure.

As nurses with prior experience in hospitals in Nigeria, some of them experienced specific interactions different from the newness any nurse might feel providing care for the first time to a patient. The environment was different and seemed complicated. The tools of the trade and policies and procedures were different and initially seemed insurmountable. Technology used in every aspect of providing care was initially intimidating. The awareness of the diverse patient population and colleagues from different cultural backgrounds and belief systems were challenging to navigate.

The Nigerian men who became nurses realized that they had chosen to become part of a relatively new phenomenon of men entering the nursing profession. They described their new belief that men can practice nursing as a profession, contrary to the perception they grew up with indicating nursing was a profession for females only. They found that there are professional codes of conduct that guide nursing practice, which help alleviate some fears and stereotypes about men in nursing. Some of the male participants described experiencing isolation among female nurses. Others described the limited uniform resources they experienced as men. For some of the male nurses, this became a call to action on behalf of the male nurses. They seemed motivated to further their education to create awareness of the needs of male nurses in general and those from Nigeria in particular.

Despite the fact the nurses seemed proud of the clinical skills and nursing education they had acquired as well as their love of working with and caring for people, they experienced what the literature characterizes as "microaggressions." The participants described these experiences as happening on occasions when both patients and colleagues did not recognize them as the

registered nurse or at best identified them as the CNA. Some of the participants talked about receiving unfair assignments compared to those given to their fellow nurses and being afraid to address the issue due to possible reprimand. Others described experiences of favoritism to others when the manager made decisions in favor of nurses from similar backgrounds. Other experiences were blatantly racial, as in the case where a patient stated the she was "allergic to black people." Microaggressions were not described as being discussed openly in their job settings, although some described taking the time to provide feedback in light of their experiences.

The Nigerian nurses expressed their perceptions of the experiences they lived through as they transitioned into the nursing career in the U.S. healthcare environment in Northern California. They described that they began their careers at the grassroots level of the nursing profession. They were challenged in navigating and working in an unfamiliar healthcare environment. They were also confronted with change in their family dynamics, diversity in the work environment and consequential microaggressions and implications, and the use of technology in healthcare.

**Research Question Two: How do the Nigerian registered nurses describe the effect of challenges on their personal and professional lives?**

One major theme that emerged is that the nurses were influenced by several factors in their choice to become nurses. The factors include caring, personal experience, job opportunity, and family and friends. That backdrop allowed the nurses to invest time and effort in ways to help them achieve their goals of becoming nurses and work in the U.S. healthcare industry in Northern California.

The perceived challenges seemed to be motivating factors that helped these nurses achieve their goals. The participants invested in formal education to support their growth and professional development and this was identified as one of the major themes. They engaged in skill building, training, and developing coping styles to overcome the hurdles they experienced. The nurses achieved significant educational degrees and many planned to continue their education to the higher levels including graduate degrees. Their growth and development strategies appear to have supported their longevity in professional practice.

Although all the participants acknowledged microaggressions and described finding ways to deflect the actions of others, they all reported being very careful during work not to misstep, believing it could lead to job termination. They also developed various coping styles to deal with the impact of microaggressions in their professional lives. "People did not believe I am nurse enough. They want a real nurse…they say can you get someone that speaks English" (Otito).

The participants described being well trained and qualified to provide nursing care in any environment regardless of cultural differences. They did not feel they deserved the negative behaviors of other nurses and patients towards them. Because they believe education may mitigate some of the negative behaviors, some participants chose to educate some of those who seemed to exhibit microaggressions toward them with the goal of helping them understand their impact. Both Osita and Otito seem to apply similar tactics in resolving some of the negative behaviors. Otito described her experience in educating the people "…if you listen very carefully, you will understand me. Some of the times I will tell them … I will slow down, maybe spell out some of the things that are very hard for them to understand" (Otito).

Afam believes that to overcome some of the challenging issues, "You have to prove yourself …you need to get good training anywhere you are and know what you are there for" (Afam). In agreement, Amina said:

> … have self confidence to knock on doors … express yourself, express your concerns and actually surprise people into … knowing that you are not just door sign and moving objects, that you are also thinking about what you are doing and you know what happens around you (Amina).

The motivating factors to practice nursing described by the nurses seemed to help the nurses overcome the possible effects of the negative behaviors meted out to them as a result of microaggressions. The nurses were of the opinion that providing education about their experiences would create awareness of the effects of such behaviors on anyone who is a victim.

**Research Question Three: What are the perceived attributes for success identified by the Nigerian registered nurses working in the U.S. healthcare environment in Northern California?**

All the participants considered themselves successful in their nursing practice. "I will definitely consider myself successful. I would say what contributed to the success is work ethic. …with a good work ethic, good training, one can definitely reach whatever they wish as they have it in them to back it up" (Ndidi).

Another participant described factors of her success are as a result of her ability to use her smartness to figure things out in her practice.

> I was successful because I'm a smart nurse, so I used my intelligence to pass the board over here. …I did not get extra training as I expected I would when I was coming over here, I had to figure things out on my own, using my experience and my brain most of the time. (Otito).

Adamma said:

> What allowed me to be successful I tell you again is being humble, being positive, and being able to take it one day at a time, being able to develop a mantra-if I don't want this to happen to me, then I wouldn't want it to happen to my patient….so treating every

> patient like I would like to be treated was another thing that made me a successful clinical nurse (Adamma).

Amina said:

> I will describe a successful nursing practice as when nursing is seen as an integral part of the healthcare team where the opinions would matter or be elicited because we are there, we see our patients, we talk the most to our patients… I think my preparation was a big part of it… My preparation was a big part of my success…all the things [that helped], the organization, the culture of my organization I think welcomed nurse's input" (Amina).

Ikenna said what contributed to his success as a nurse is, "…never taking things for granted because so many people are suffering. So for every opportunity or chance you get, you have to take advantage of it." (Ikenna). Chima described being successful as:

> So for me …to be successful is putting the patient, their family and their needs [first]. If you are able to meet those needs, then you are successful. I think the main thing is communicating, being able to relate to the patient, to the staff-your fellow co-workers, to management, and to the interdisciplinary team and being prepared to practice each day you get to work. (Chima).

Osita seems to agree with Chima and said:

> I think a successful nurse is one that makes a positive impact on the patient, positive impact on their health, positive impact on their mind, and their general well being. …as a nurse, you are not just taking care of their health, you are taking care of everything, and you know humor is very important. …I am able to laugh with the patient. So I am more fulfilled after, at the end of my shift and I see my patients smiling and … they are happy with my care, taking care of their pain and everything else they need. I also add a personal touch to it …I feel successful when at the end of my shift my patient says, I want to thank you so much for taking good care of me. I really feel appreciated you know. I mean it makes me feel fulfilled and I know I made a difference. (Osita).

Nnam agrees with Ikenna above and said:

> …you really have no reason not to succeed or take advantage of the opportunities that are out there. He also echoed Chima above and said … a successful nurse is a nurse who is able to represent the profession and be the best at whatever area in nursing that they find themselves, and not be lacking in providing the services. …if you are on the floor, you should do your best and be recognized as a very credible, attentive and knowledgeable nurse. If you are teaching, you should be a good teacher, … in whatever area you find yourself, you should excel in that area… and that should be the success (Nnam).

Afam simply said success is:

> If you are able to do this job [nursing] on a daily basis for so many years as I did and retire by yourself, without getting into trouble one thing or the other they take your license or suspend your license… or get terminated. …if you are able to work so many years in places like that and finish then decide to retire. … you have to put more and do more so you have to adjust each time management demands more … So you have to step up to the expectation. You have to be disciplined and advise yourself to move on. (Afam).

Onyeka echoed similar sentiments as Afam saying:

> What allowed me to be successful I think is because I don't try to get into trouble with everything. You just keep going. I don't fight a battle I know that its not worth it you know. Again I am very hard working person. I pretty much focus on what I do. I know why I am here …(Onyeka).

Chioma seem to think that her success is based on the combination of hard work and prayer:

> Number one is as a Christian I don't leave my house without praying … I commit myself, my job, everything I am doing and my family to God's hands … Secondly, I try to be aware of my surrounding. Be ready to know what you are doing. That's what keeps me successful. Be ready to give the best care you can you know. Go above and beyond in your care, in your call of duty. (Chioma).

Ozimma initially used one word "determination" to describe success based on her grassroots efforts in pursuing nursing as a profession. On another note, she reflects that "Well I am able to save lives. For me, that's what I feel is success … it makes me feel good that I am able to help people that are in need that can not help themselves. So that's what I call success for me." (Ozimma).

The participants identified caring, personal experience, job opportunity, and family and friends as the subthemes of the influencing factors to be a nurse. These factors seemed to play very strong roles in the participants' perceived successes. The factors seemed to be the driving forces that allowed the participants to consider the challenges as mere hurdles on their way to their goal. Therefore, success seemed to be defined based on having the passion to enjoy caring

for others through hard work, being focused at work, having family support, and positive patient outcomes. Of note is that none of the participants measured success in terms of money. Although they all appreciated that they were making a good living working as nurses, caring for their patients seemed to be their preferred way to mark success.

## Recommendations

The number of Nigerian nurses seeking to work in Northern California and other states in the U.S. is increasing. The findings of this study provide insight into the lived experiences of Nigerian registered nurses working in the healthcare industry in Northern California. The findings also have presented some new phenomena worth exploring in the future.

### Recommendations for Practice

**Increase Curricula/um in Nursing Cross-cultural Education.** Training should include all ethnicities in cross-cultural education with goals to build understanding and acceptance across differences and to identify and eliminate behaviors that become microaggressions.

**Educate leaders to respond to microaggressions.** Line managers, and senior leaders in Northern California Healthcare Organizations need to be trained to be aware of the issue of microaggressions in the work place, in order to develop proper administrative interventions to address the resulting negative effects, and provide proper support for all the nurses.

The healthcare organizations in Northern California and their human resource departments should evaluate the negative impact of microaggressions behaviors in relation to nursing professional activities. This will help identify issues in activities around scheduling and staffing, safe patient assignment, appropriate education and training, and providing policies around non-tolerance of such behaviors.

**Need to support Nigerian nurses to be successful in their practice.** As Nigerians continue to seek careers in the nursing profession, they should be ready to embrace grassroots efforts in education and training to become successful. They are encouraged to be aware of the reality of microaggressions behaviors that could have a negative impact on their enthusiasm to be professional nurses. They should also be aware that those who seemingly have succeeded did so because they had passion for the profession and cared about helping others, they were focused at work, they had family support, they exhibited self confidence, they were resilient to negative behaviors toward them, and they did not define professional success in terms of money. They turned their challenges into motivating factors to educate themselves and those around them.

**Support for accessing nursing jobs commensurate with education and training.** Nigerian nurses in this study, while holding RN degrees frequently accepted positions requiring less education to access initial positions. There is a need to develop peer mentoring programs to support those Nigerian nurses and nurses from other cultures seeking to develop and sustain their nursing career. Learning professional job search tactics may help the nurses seek proper job level.

## Recommendation for Further Research

Further research will deepen the understanding of the essence of Nigerian nurses' experiences.

**Expand this study nationally**. This study was limited to the self-identified Nigerian registered nurses working in the healthcare industry in Northern California. Additional research is needed to explore the experiences of Nigerian registered nurses in other locations in the U.S. to confirm and deepen understanding of their experiences. This may lead healthcare

organizations to reassess and update their policies to assure that an increasingly diversified workforce is treated without bias.

**Deepen research on the lived experiences of Nigerian men in the nursing profession.** Further study is recommended to understand the lived experiences of Nigerian men in the nursing profession.

**Deepen research on the impact of microaggressions**. Further study of microinvalidation as a form of aversive racism and the impact on the health and professional practice of the targeted individuals and the organizations where they work is recommended. The findings will help create more awareness and identify the associated behaviors leading to possible rules against such behavior.

## Summary

This chapter offers an overview of the study recapturing the study's purpose and overarching research questions. Findings and results offered in Chapter 4 provide a trail of evidence for the study's conclusions and recommendations. The findings from this study contribute to the understanding of the lived experiences of Nigerian nurses working in the healthcare industry in Northern California.

The study yielded four themes: (a) influences to become a registered nurse, (b) developing professionally, (c) transitions experienced, and (d) responding to challenges. Further theme and subtheme analysis led to identification of four results and interpretations that offered more insight to the shared experiences of the nurses. The four results are: (a) universality of fundamental core nursing clinical practice skills, (b) grassroots effort in seeking access into the nursing profession, (c) significant experiences of microaggressions, and (d) limited support and need for resiliency.

Perhaps most importantly they specifically called attention to the presence of racially aversive "microaggressions" experienced by the Nigerian nursing workforce. The healthcare industry and workforce needs to be aware of behaviors exhibited that lead to invalidation and seek ways to eliminate them from within the workplace. Patient education is also necessary.

The conclusions identified the challenges faced and defined behaviors that support these nurses success including: (a) passion to care for people at their most vulnerable state of health as a driving force behind the interest in the nursing profession, (b) continuous education and training to enhance their knowledge and stay current with the changes in the profession, (c) having self-confidence and the ability to be focused at work, and (d) to be aware of obvious cultural differences and the possible negative impact not as a hindrance but as a mere hurdle on the path to successful nursing practice. Several recommendations have been identified to further deepen the research on the experiences of Nigerian nurses working in the U.S. and the need to create awareness in the healthcare industry for proper support of all nurses.

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## Appendix A: Interview Protocol

Date: _____ Time: _____ Location: _____

Interviewee: Interviewee (Pseudonym): _____

Thank you for joining me for this interview to talk about your lived experience as a Nigerian registered nurse working in the United States' healthcare environment in northern California. Your lived experiences will allow me and others to develop a deeper appreciation for your experience. I will be asking questions about your experience as a Nigerian registered nurse working in United States' healthcare industry in northern California.
Think of this interview like any other conversation where you freely respond as you see appropriate. I will ask you some follow up questions, but I really hope that you will feel free to tell me the experience you believe is important that I hear. That means you should feel comfortable providing a response that is more comprehensive than the specific question asked.

**Background**

Your age: A. 20-29------- B. 30-40------ C. 41-50------ D. 51-65-----

1. I am A. Married----- B. Single-----
2. Education: A. BSN------ B. MSN----- C. Other-----
3. Where did you receive your initial nursing training?
4. How did you train to become a nurse in the US?
5. How long have you worked in the United States?
6. What type of healthcare facility do you work in currently?
7. What other US healthcare facilities have you worked in previously?

**Perception of US healthcare and professional nursing**

1. How did you decide to become a nurse in the US?
2. What were your expectations for practicing nursing in the US?
3. How does being a nurse in the U.S. differ from being a nurse in Nigeria?
4. What experiences have you had working as a nurse in the US healthcare system?
5. What skills have been most important to your practice of nursing in the U.S.?

**The perceived challenges and success of nursing practice**

1. As a Nigerian, what challenges have you faced in healthcare settings in the U.S.?
2. What communication issues have you faced in your practice of nursing in the U.S.?
3. How have you dealt with the issues and challenges you experienced?
4. Describe factors that have helped you achieve success in the US?
5. What advice would you offer to other nurses from Nigeria regarding practicing nursing in the US?
6. What else would you like me to know about your experiences with being a nurse in Northern California?

## Appendix B: Invitation to Participate

Email/Phone invitation to participate along with criterion for qualification

Dear_____,
My name is Agatha Ekeh. I am a Doctoral candidate in the School of Education at Drexel University Sacramento. I am contacting you as a possible participant in research that I am conducting. I am committed to developing a greater understanding of the lived experiences of Nigerian registered nurses working in United States' healthcare industry in northern California. The title of my study is "Globalization and nursing practice: A phenomenological study of the lived experiences of Nigerian registered nurses working in the United States' healthcare industry in northern California". The purpose of this phenomenological study is to explore the lived experiences of Nigerian registered nurses working in the United States' healthcare environment in northern California. The objective of the research is to enable healthcare organizations and the nurses to effectively apply their available resources in training and learning through an understanding of their lives and the challenges they face, and the support systems available for their success.
To be eligible to participate in the study you need to be:

1) Self identified as a Nigerian registered nurse who attained his/her nursing credential in studies within or outside the United States
2) Have worked for at least one year in United States' healthcare environment in northern California
3) Able to participate in one interview (length approximately 45 – 75 minutes)

When you indicate your interest in participating, a teleconference will be held to discuss the study. Those who volunteer will participate in a 45 to 75 minute interview conversations. The conversations will be recorded to assure that your words, voice, and experiences are accurately represented.
Thank you in advance for your consideration. I hope you will join the study. Please e-mail me to indicate your willingness to participate (aee43@drexel.edu).
Best,
**Agat**ha Ekeh
Doctoral Candidate in Educational Leadership and Management
Drexel University Sacramento
aee43@drexel.edu
415-722-6107

**Follow-up Email to Participants**

Date _____

Dear _____.

I am writing to thank you for your response and invite you to participate in my doctoral research project titled: "Globalization and nursing practice: A phenomenological study of the lived experiences of Nigerian registered nurses working in the United States' healthcare industry in northern California".

The purpose of this phenomenological study is to explore the lived experiences of Nigerian registered nurses working in the United States' healthcare environment in northern California. The objective of the research is to enable healthcare organizations and the nurses to effectively apply their available resources in training and learning through an understanding of their lives and the challenges they face, and the support systems available for their success. This study is conducted as part of the dissertation requirement for my Doctoral Degree in Educational Leadership and Management at Drexel University under the supervision of Dr. Kathy Geller, dissertation Supervising Professor at Drexel University.

Please let me know of a preferred phone number to reach you to finalize the meeting time and place and explain the informed consent form.

For the purpose of data collection, I request that I be permitted to audio record the interview using two devices (one for back up) and take handwritten notes through the process based on my observation. The data collected will be secured in drives without Internet access and maintained in a locked drawer in the investigator's office through the study and after up to three years. Interview recordings and transcriptions will not be shared. They will be used only for the purpose of this study. The recording, observation notes and interview transcripts will only be reviewed by myself and then only for purposes of identifying key themes, findings and results from across the interviews.

Participation in this study is voluntary. All participants and the name of the organization will remain anonymous, and only identified with a pseudonym. You are free to decide not to participate or to withdraw from the study at any time without consequences. There are no known risks and/or discomforts associated with this study.

If you have questions, I would be happy to talk in more detail. I can be reached at (415) 722-6107 or via email at aee43@drexel.edu).

Thank you for your time. I look forward to your response and confirmation of the time denoted above.

Sincerely,

Agatha Ekeh
Doctoral Candidate, EdD. in Educational Leadership and Management
Drexel University, School of Education
(415) 722-6107
Email: aee43@drexel.edu

## Appendix C: Informed Consent

**Drexel University**
**Consent to Take Part In a Research Study**

1. **Title of research study**:
   Globalization and Nursing Practice: A phenomenological study of the lived experiences of Nigerian registered nurses working in the United States' healthcare industry in Northern California

2. **Researcher**:
   4. Kathy D. Geller, Ph.D., Principal Investigator, Assistant Clinical Professor, Drexel University School Of Education

Agatha E. Ekeh, Co-Investigator, Doctoral Candidate, Drexel University, Sacramento Campus

3. **Why you are being invited to take part in a research study**

   We invite you to take part in a research study because you are a registered nurse from Nigeria working for at least one year in United States healthcare environment northern California

4. **What you should know about a research study**

- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part now and change your mind later.
- If you decide to not be a part of this research no one will hold it against you.
- Feel free to ask all the questions you want before you decide.

5. **Who can you talk to about this research study?**

If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research team at If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research team: Agatha Ekeh at 415-722-6107 or aee43@drexel.edu who is conducting the research. Additionally you may also contact Dr. Kathy Geller who is supervising the study at 916-213-2790 or kdg39@drexel.edu.

This research has been reviewed and approved by an Institutional Review Board (IRB). An IRB reviews research projects so that steps are taken to protect the rights and welfare of humans subjects taking part in the research. You may talk to them at (215) 255-7857 or email HRPP@drexel.edu for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.

- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

**6. Why is this research being done?**

The purpose of this phenomenological study is to explore the lived experiences of Nigerian registered nurses working in the United States' healthcare environment in northern California to understand the cultural, social, and professional challenges that they face.

**7. How long will the research last?**

We expect that you will be in this research study for a single face-to-face interview lasting about 45- 75 minutes. Interviews are planned to be conducted between July - August 2015. The analysis of data and subsequent research report will be presented as a Doctoral Dissertation that will be completed by December 2015.

**8. How many people will be studied?**

We expect about twelve to fifteen Nigerian registered nurses working in healthcare environment in northern California will be in this research study.

**9. What happens if I say yes, I want to be in this research?**

- You will be invited to contact the researcher by phone or email to arrange for an interview.
- All participants will be identified by a pseudonym and assessed for qualification to be included in the study.
- You will be required to sign a consent form. The consent form provides explanation for the study process, privacy and confidentiality as well as the participant's right to withdraw from study at any time without penalty.
- Prior to the start of the interview, Ms. Ekeh, Doctoral Candidate at Drexel University School of Education will review the consent form with you and gain your written consent to participate in this process.
- You will interact with Ms. Ekeh, Doctoral Candidate at Drexel University School of Education during the data collection process that will last for about 45-75 minutes.
- The interview will be at a location that is convenient to you.
- The interview will be conducted sometime in July to August 2015.
- The individual interview sessions will be conducted using face-to-face approach, will be tape-recorded, transcribed verbatim, and coded for analysis and identify the emerging themes.
- The analysis of data and subsequent report as a Doctoral Dissertation will be completed by December 2015.
- Your personal identification will be protected by the use of pseudonyms. For security, the data will be stored in a location without Internet access, and with backup copies. Data will be reviewed with the participants to ensure accuracy of transcription from the raw data.
- At the end of the interview, the researcher will request you identify a potential qualified participant/s to be interviewed.

**10. What are my responsibilities if I take part in this research?**

If you take part in this research, it is very important that you:

- Follow the investigator's or researcher's instructions.
- Tell the investigator or researcher right away if you are unable to continue with the research process.

**11. What happens if I do not want to be in this research?**

You may decide not to take part in the research and it will not be held against you.

**12. What happens if I say yes, but I change my mind later?**

If you agree to take part in the research now, you can stop at any time it will not be held against you.

**13. Is there any way being in this study could be bad for me?**

***There is no inherent risk to participate in this research study including physical, psychological, privacy, legal, social or economic risk to the participants.***

**14. Do I have to pay for anything while I am on this study?**

There is no cost to you for participating in this study.

***15. Will being in this study help me in any way?***

We cannot promise any benefits to you or others from your taking part in this research.

There are no benefits to you from your taking part in this research. We cannot promise any benefits to others from your taking part in this research.

**16. What happens to the information we collect?**

Efforts will be made to limit access to your personal information including research study records, treatment or therapy records to people who have a need to review this information. We cannot promise complete secrecy. Organizations that may inspect and copy your information include the IRB and other representatives of this organization. Efforts will be made to limit access to your personal information including research study records, treatment or therapy records to people who have a need to review this information. We cannot promise complete secrecy. Organizations that may inspect and copy your personal information include the IRB and other representatives of this organization. Following completion of the study, the principal investigator will maintain in a locked cabinet in her office for a period of three years the following original records: correspondence, research proposal, data collection instrument, data and result, audio tapes, protocols, Drexel IRB submission, approved informed consent form, and any other documents required by regulations. Following that, if there is no more use for it, data collected for this study will be destroyed. If additional publications are in process, the data will be maintained in the locked cabinet in the primary investigator's office.

We may publish the results of this research. However, we will keep your name and other identifying information confidential.

**17. Can I be removed from the research without my OK?**

No. The researcher does not anticipate any reason to terminate participation.

**18. What else do I need to know?**

This research study is being done by Drexel University. There is no inherent risk to participation in this research study including physical, psychological, privacy, legal, social or economic risk to the participants.

## Appendix D: Template for Field Notes

| Descriptive Notes | Reflective Notes |
| --- | --- |
| | |